STATE TITLE V BLOCK GRANT NARRATIVE
STATE: CT
APPLICATION YEAR: 2006

I. GENERAL REQUIREMENTS

A. LETTER OF TRANSMITTAL

The Letter of Transmittal is to be provided as an attachment to this section.

B. FACE SHEET

A hard copy of the Face Sheet (from Form SF424) is to be sent directly to the Maternal and Child Health Bureau.

C. ASSURANCES AND CERTIFICATIONS

The assurances and certifications are on file at the Connecticut Department of Public Health and are available from:

Terry Mrowka
Director, Office of Affirmative Action
Connecticut Department of Public Health
410 Capitol Avenue
P.O. Box 340308
Hartford, CT 06134

D. TABLE OF CONTENTS

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published June, 2003; expires May 31, 2006.

E. PUBLIC INPUT

A Public Hearing for the MCH Block Grant was held on June 8, 2005. A Notice of Public Hearing for the Title V application was posted on the DPH website, in eight CT newspapers, sent via email to providers and contractors, as well as through several CT family Listserv newsgroups. In attendance this year were representatives from four community provider agencies (a total of eight people), one mother and representatives from the Department of Public Health.

Oral testimony at the hearing included highlights from programs describing accomplishments that would not be available without support from Title V funds. Other comments included how Title V funds could enhance CT's FIMR program as well as provide an enabling service to formal education and training for the outreach services staff. The hearing was audio-recorded.

In response to the Invitation for Written Testimony, feedback was received from six community organizations. Comments addressed the importance of DPH's support of FIMR programs; health disparities in infant mortality and the uninsured African-American population; how Title V supports CT's Healthy Start Program goal of decreasing infant mortality; and how Title V addresses the health care needs of CT's minority communities. Written testimony is on file.

Throughout June 2005, families were compensated for their time to review and comment on this year's block grant application for Connecticut. This report can be found as an attachment to this section.

II. NEEDS ASSESSMENT

In application year 2006, the Needs Assessment must be provided as an attachment to this section.

III. STATE OVERVIEW

A. OVERVIEW

Connecticut is a relatively small state of about 5,000 square miles and 3.5 million persons. Nearly one million of Connecticut residents are between the ages of birth to 19, amounting to 27% of the state's population (1). It is clear that the population in Connecticut has become more diverse during the past decade. The Hispanic, Asian, and African American/Black population increased an estimated 50, 68, and 13 percent respectively since the 1990 census, while the white population decreased 4 percent. The white non-Hispanic population comprised 83.8 percent of the Connecticut population in 1990, but that percentage dropped to 77.5 in 2000 and has remained level since then (2). See Table 1 in the document attached to this section.

I. Maternal and Child Health Indicators

A. Maternal and Child Demographics

With Census 2000 information released, a more detailed picture of Connecticut and the United States became available. As the Census Bureau releases Supplemental Population Estimates, comparisons can be made on residents of Connecticut and the United States. See Tables 2 and 3 in the document attached to this section. Residents of the major cities (Bridgeport, Hartford, and New Haven) tend to be younger, unmarried, poorer, less educated, more likely to be unemployed, on public assistance, and be Hispanic or African American/Black than the state as a whole. These comparisons are in stark contrast to the demographics of some wealthy suburbs such as Darien and New Canaan.

Many indicators of maternal and child health within Connecticut compare favorably with the United States as a whole, however, there are high risk groups which experience a greater share of the burden of adverse health risks and outcomes. In Connecticut in 2002, an African American/Black baby was two and a half times more likely to die within its first year of life than a white baby, twice as likely to have late or no prenatal care, and almost twice as likely to be born with low birthweight. See Table 4 in the document attached to this section. These disparities are documented in more detail in the Needs Assessment that was completed as part of the 2006 MCHBG Application. Reducing the disparities in maternal and child health indicators remains one of the major challenges facing the public health community.

B. Infant Mortality

The overall infant mortality rate has declined in the United States and Connecticut during the past two decades (3). However, African American/Black babies consistently have had higher infant mortality rates than White and Hispanic populations in Connecticut and in the U.S. From 1981 to 2003, Connecticut's infant death rate fell from 12.0 to 5.3 deaths per 1,000 live births. However, the infant mortality rates for African Americans/Blacks in 2003 was 11.5 and substantially exceeded the rates for whites in all years from 1981 to 2003. See Figure 1 in the document attached to this section.

This gap reflects the consistently higher prevalence among the non-white population for risk factors, such as birth rates among teenage women, lack of adequate prenatal care, and low birthweight. Targeting prevention programs to groups showing a high rate of low and very low birthweight infants (such as women in the urban centers or the state's African American/Black population) may produce the greatest effect on reducing the overall risk factors among the non-white infant population in the state.

Programming within the Department of Public Health (DPH) to reduce infant mortality is aimed at the period before conception, along with the prenatal and postnatal periods. Pre-conception interventions aimed at school-aged audiences and women of childbearing age include primary care services, targeted health education programs, and outreach and case-finding to link individuals and families to primary and preventive services. Prenatal efforts are focused on getting mothers into regular care early in the pregnancy and keeping both regular and specialty care appointments as directed by their

health care provider. Postnatal efforts include medical testing for genetic disorders and maintaining good health for healthy infants and their mothers.

C. Births to Teens

Teen birth rates declined dramatically during the past decade as the birth rate for teens age 15-19 dropped from 59.0 to 43.0 per 1,000 teens nationally between 1993 and 2003. In Connecticut, the rate dropped from 38.8 to 25.8 infants born per 1,000 female teens (4). An African American/Black or Hispanic baby born in CT in 2003 was approximately 4 to 5 times more likely to have a teenager as a mother than a white baby. See Figure 1 in attachment to this section.

According to the National Center for Health Statistics preliminary birth data for 2003, Connecticut ranked fifth in the nation for its teen pregnancy rate for 15-19 year olds, with a rate of 25.8 births per 1,000 females ages 15-19 in comparison to the national rate of 43.0 (4). The percent of births to teens varies by race and ethnicity. The overall percent of births to teens has dropped in the last decade, especially among African Americans/Blacks. However, there remains a greater percentage of pregnancies among teens in the African American/Black and Hispanic populations when compared to white teens. See Figure 2 in the document attached to this section.

Teen pregnancy is considered a public health problem for several reasons related to the health of both the mother and newborn. Early sexual activity can result in a higher risk for sexually transmitted diseases, which could harm the fetus and impair the future fertility and health of the mother. Preventive interventions to address teen pregnancy through Connecticut's Title V programs include programs to delay the onset of sexual activity, promote abstinence as the social norm, reduce the number of adolescents who have sex at young ages, and increase the number of sexually active adolescents who use contraceptives effectively. State-sponsored specialized programs such as the Right from the Start Program serve pregnant and parenting teens. This program provides intensive case management services with emphasis on promoting positive pregnancy outcomes, positive parenting and breastfeeding.

D. Prenatal Care

Non-adequate prenatal care is a composite measure, reflecting both the time of the first prenatal visit and the number of visits. The "non-adequate" grouping includes both "inadequate" and "intermediate" care as defined in the Kessner Index of prenatal care (5). Adequacy of prenatal care has improved during the past decade. Although the gap is closing in differences in race, adequate prenatal care is less often achieved by African American/Black and Hispanic women. See Figure 3 in the document attached to this section. In 2002, 2.0 percent of CT women received late or no prenatal care in comparison to 3.6 percent nationally. Connecticut ranked one of the lowest rates of late or no prenatal care, along with the other New England states (6).

The Department has tried to improve access to prenatal care through several strategies, such as supporting sites for primary care and free pregnancy testing at family planning clinics. At these sites, patients are appropriately referred for early prenatal care, in keeping with established protocols.

E. Low Birthweight

Low birthweight (under 2,500 grams) is a major cause of infant mortality and long-term health problems. The impact of low birthweight on infant mortality occurs primarily during the first 28 days of life (the neonatal period), when low birthweight infants are about 40 times more likely than normal weight infants to die. For very low birthweight infants (less than 1,500 grams or 3 lbs. 3 oz), the risk of death is 200 times higher than among normal-weight newborns. See Figure 4 in the document attached to this section. In 2003, 7.5 percent of births had low birthweight in Connecticut in comparison to 7.9 percent nationally (4). While there have been improvements in the infant mortality rates, low birthweight has remained relatively stable for the past two decades. Low birthweight is more common among infants of African American/Black and Hispanic mothers. Likewise, twins and

multiple births have a higher frequency of low and very low birthweights compared with singleton newborns.

F. Other MCH Indicators

The positive maternal and infant health effects of breastfeeding have been well documented. The estimated rate of breastfeeding in Connecticut has improved from 68.7% to 69.3%, just shy of the state's goal (69.5%). Generally, the rate of women in Connecticut breastfeeding while in the hospital is 73.2% and at 6 months the rate is 28.3% (7). Thus, the rate of initiation of breastfeeding among all women has improved (as indicated by hospital rates) but declines rapidly by six months. The role of the Title V program has been to promote breastfeeding as a social norm in the state. Other infrastructure building activities included conducting a statewide needs assessment of the breastfeeding practices of Black and African American women to determine how best to promote and support breastfeeding in this population, which breastfeeds at a lower rate than other groups.

Although pregnant women in CT were less likely to smoke than their counterparts nationwide (see the CT Needs Assessment), smoking during pregnancy remains a public health issue. The role of the Title V program is multi-fold and includes functioning as a partner with the DPH's Tobacco Control Program to address smoking cessation during pregnancy, as well as with federal and regional level initiatives (i.e. -- National Partnership to Help Pregnant Smokers Quit), which can be implemented at the state level. Other infrastructure building activities including the facilitation of meetings with the state DSS and Managed Care Organizations (MCOs) to discuss reimbursement mechanisms for smoking cessation products and support services.

II. Other Indicators

A. Socioeconomic Indicators in Connecticut

In Connecticut, there is a disparity between the wealthiest and poorest citizens. While Connecticut is one of the wealthiest states in the country, several cities have high rates of poverty. With a median household income of $55,004, Connecticut was ranked fifth in the nation (8) in 2003. Within Connecticut, however, the median family income and other characteristics recorded in the 2000 Census vary within the State and its large cities, and New York suburbs. While many children within Connecticut lived in affluent homes, nearly 86,000 lived below the poverty level (9). In Hartford, over 40% of the children were estimated to be living in poverty (10), a figure surpassed only by one other city in the nation with a population over 100,000. Despite its relative wealth, and with recent decreases in state revenues, efficiency is paramount to reversing child health disparities within the state. The economic disparity experienced by the cities is mirrored in differing maternal and child health statistics. See Table 5 in the document attached to this section.

The economic recession that began mid year 2000 appears to have ended, recovering from a downturn in the economy since the terrorist attacks of September 11, 2001. Between September 2003 and March 2005, Connecticut recovered 28,000 of the 61,000 jobs lost since 2000 (11). The state's economy is supported predominantly by services, manufacturing, and retail trade industries. Unemployment in Connecticut has risen to 5.3 percent in comparison to 5.1 percent nationally (12).

B. Health Care Delivery Environment in Connecticut

Connecticut does not function on a county-based system for the delivery of public health services to its residents. Direct health care services are delivered to residents through a wide range of providers including, but not limited to, school based health centers, community health centers, outpatient clinics, physicians offices for primary care services; free-standing and hospital-based outpatient surgical centers for diagnostic or minor surgical procedures; acute care hospitals for emergency care, routine outpatient or inpatient services; long term care facilities for chronic care or rehabilitative service; and increasingly non-institutional settings, such as the home, for services ranging from intravenous infusion of medications to physical therapy. The licensure or certification of health care facilities and

health care professionals guides promotion of high quality health care and services. Utilization of services is dependent upon a variety of demographic, economic, social and environmental factors, all of which are considered when planning the delivery of Title V programs, services and activities.

Perinatal Care in CT is provided through a network of Healthy Start Providers. The Healthy Start Program is a collaboration between the State Departments of Social Services (DSS) and Public Health. The goal of the state Healthy Start Program is to promote positive birth outcomes and maternal and infant health among at-risk, low income families in CT. The DSS contracts with 5 agencies statewide, which in turn contract with other community based providers to provide case management services to pregnant women and their children up to age three. To complement the Healthy Start program, CT also has a Nurturing Families Network, which operates in all twenty-nine birthing hospitals in the state. It provides parent education and support for first time parents. Unlike the Healthy Start program, families are enrolled in the Nurturing Families Network when they are expecting or have just given birth to their first child.

Connecticut is part of the national trend in the delivery of health care services in which managed care has expanded and has become the dominant financing mechanism. The Connecticut care delivery system is challenged by managed care and the lack of sufficient services for the uninsured. These methods of financing affect not only the availability and delivery of services, but also the quality of patient outcomes. Hospital mergers have occurred in Connecticut and length of stays in hospitals have decreased, as has the rate of hospitalizations (13).

C. Safety Net Providers

Safety Net Providers comprise the system of care that addresses the needs of those individuals who experience barriers when accessing the traditional health care system. Some of these barriers include financial, transportation, cultural, linguistic, etc. One of the primary groups targeted by safety net providers are the uninsured. In Connecticut, the safety net provider system is comprised of Community Health Centers, School Based Health Centers, Visiting Nurse Associations, Local Health Department and Family Planning Clinics. Maintaining and supporting the safety net providers is a priority for the State. With increasing financial challenges, CT's focus is to avoid the erosion of this health care delivery system. During the 2005 legislative session, the Torrington Community Health Center, an FQHC look-alike, was allocated state funding and the remaining CHCs were given a small cost of living adjustment.

D. Health Insurance

HUSKY (Healthcare for UninSured Kids and Youth) is Connecticut's health insurance plan for children and families. In 1997 when the federal government created the State Children's Health Insurance Program, Connecticut renamed part of its Medicaid program that serves children and low-income families "HUSKY A" and established the "HUSKY B" program for uninsured children with family income that exceeds the HUSKY A limits. Both HUSKY A and B are managed care programs, administered through the Department of Social Services and private health plans.

HUSKY A covers pregnant women and children in families with income under 185% of the federal poverty level. HUSKY A provides preventive pediatric care for all medically necessary services. It also covers parents and relative caregivers in families with income under 100% of federal poverty. There are 310,878 persons, including 218,420 children under 19 in HUSKY A as of May, 2005. The basic HUSKY package includes preventive care, outpatient physician visits, prescription medicines, inpatient hospital and physician services, outpatient surgical facility services, mental health and substance abuse services, short-term rehabilitation and physical therapy, skilled nursing facility care, home health care and hospice care, diagnostic x-ray and laboratory tests, emergency care, durable medical equipment, eye care and hearing exams, and dental care (14).

HUSKY B provides health care for children without employer-sponsored coverage for a sliding fee. There are 15,640 children under 19 in HUSKY B as of May, 2005 (15). As part of HUSKY B, HUSKY

Plus provides supplemental benefits for Children and Youth with Special Health Care Needs enrolled in HUSKY B. Services include Multidisciplinary teams (Pediatricians, Advanced Practice Nurses, Benefits Specialists, Family Resource Coordinators and Advocates) who work with families to identify their child's care needs and the resources to meet those needs. Community-based mental health and substance abuse services to children and youth with intensive behavioral health needs are also offered under HUSKY Plus.

In a January 2005 review of 2003 HUSKY data, the Connecticut Voices for Children found that just over half of the children covered by HUSKY received well-child care in 2003, with the utilization rates being the lowest among older adolescents (aged 16-19 years) (16). Utilization was lower for dental care, with only 47% of enrolled children having any dental care in 2003. While there have been improvements in dental care utilization rates during the past few years, fewer than half of enrolled children who are eligible for preventive dental care services through HUSKY A actually received these services (17).

There have been changes that limit eligibility or enrollment. On July 1, 2005 families now only receive Transitional Family Assistance (TFA) for one year rather than two years. As of July 1, 2005 new and increased premiums will be imposed on children in HUSKY B. Also there is elimination of self-declaration of income mandating that applications received after July 1, 2005 show documentation of income. Fortunately there are changes that improve eligibility and enrollment, presumptive eligibility for HUSKY A children is being restored and now pregnant women experience expedited eligibility when enrolling in HUSKY A. Another improvement is that DSS is implementing increased income guidelines for parents and caretaker relatives with incomes between 100% and 150% of the federal poverty level effective July 1, 2005.

Connecticut Voices for Children released a report on Births to Mothers in HUSKY A (18). In 2002, there were 41,191 births to Connecticut residents, including 9,775 births (24%) to mothers enrolled in HUSKY A when their babies were born. Compared to other mothers who gave birth that year, mothers who were enrolled in HUSKY A were younger (average age 25, compared with 31 for other mothers) and far more likely to be teens (21% vs. 3% of other mothers). They were more likely to be Black non-Hispanic (25% v.7%) or Hispanic (32% vs. 12% of other births).

Health insurance is an important component of access to health care. People without health insurance are less likely to receive the basic health care services that the insured receive. In some cities and towns, HUSKY A covered a far greater proportion of pregnancies. In these communities, the importance of HUSKY A for improving maternal health and birth outcomes cannot be overstated. The collaborative efforts of HUSKY, prenatal care providers, community-based organizations, and other Title V funded programs are essential for ensuring that women become pregnant when they chose to, begin pregnancy in good health, begin prenatal care early, and obtain risk-appropriate high quality prenatal care and social support services throughout pregnancy (18).

As the Title V agency in Connecticut, DPH has contributed policy guidance and technical assistance to the HUSKY program by:

- Enhancing enrollment in HUSKY by participating in the Covering Connecticut's Kids coalition, a network of organizations involved in HUSKY outreach (including DSS, Benova, and Infoline)
- Partnering in the work to expand Katie Beckett waiver and other related DSS waiver applications that will support access to comprehensive care for children and youth.
- Working with the State Medicaid Managed Care Council to promote outreach for prenatal access in first trimester and Medicaid reimbursement of care coordination services to improve access to pediatric primary health care access under Early Periodic Screening and diagnostic and Treatment Services.
- Working with State Commission on Children, HUSKY and other Connecticut key stakeholders in promoting home visitation for mothers with newborns, particularly at risk mothers using Healthy Start and Nurturing Families Programs.
- Working with Local Health Departments and Immigrant health to improve health status of the

Connecticut residence.
- Providing care coordination and respite care as well as family support services to children with special health care needs in HUSKY as a way of filling the gaps in care
- Developing linkages between HUSKY and state public health programs such as WIC, childhood immunizations, Medical Home Learning Collaborative of primary care physicians, School Based Health Centers (SBHC), Community Health Centers, Family support council, and other essential community providers and Title V funded programs, (including an MOU with DSS regarding these linkages)
- Facilitating the process by which School Based Health Centers (SBHC) are named as the only essential community providers in the DSS waiver application, resulting in all SBHCs having contracts with all managed care plans for Husky A and B
- Supporting Community Health Centers/Connecticut Primary Care Association and SBHCs in their efforts to receive statewide outreach grants for Husky B
- Utilizing existing services to create access points for referral or applications to enhance outreach and enrollment
- Identifying and developing needed enabling services through work with other providers and local health departments; and the implementation of quality improvement activities and evaluation.

A growing concern is the national and state trend among the Hispanic population being disproportionately underinsured. Although Hispanics are 10 percent of Connecticut's total population, they constitute 40 percent of its uninsured. Hispanics are five and a half times more likely to be uninsured as persons from all other ethnic or racial groups. This result reflects a national phenomenon. Hispanics are significantly less likely than non-Hispanics to have health coverage, to have a regular health care provider, and to receive regular preventative care and screenings (19).

E. Racial and Ethnic Disparities

Reducing the disparities in maternal and child health indicators remains one of the major challenges facing the public health community. When reviewing Connecticut's maternal and child health indicators, racial and ethnic disparities are quite evident. According to the "Policy Challenges and Opportunities in Closing the Racial/Ethnic Divide in Health Care" (20), a multi-level strategy must be employed to address the potential causes of racial/ethnic disparities. In CT some of the strategies have included: 1. Improving the number and capacity of providers in underserved communities by continuing to function as a liaison in the recruitment and retention of primary care health professionals. This particular activity is carried out by the Primary Care Office within the DPH and by working collaboratively with the CT Primary Care Association. 2. Increasing the knowledge base on causes and intervention to reduce disparities by collecting and analyzing data on heath care practices and use across racial and ethnic groups. In a study of Latina adolescent women in CT who were pregnant, they all reported that their pregnancy was "accidental" and that if they thought they would have become pregnant they would have "delayed sexual activity" (21). The DPH is also in the process of finalizing a study on the breastfeeding practices of African American/Black women. CT's PRAMs-like study or the Pregnancy Risk Assessment Tracking Survey (PRATS) data is currently being weighted and should provide additional racial and ethnic specific MCH data. 3. The re-establishment of the DPH's Office of Multicultural Health in raising public and provider awareness of racial/ethnic disparities in health care. The Office is responsible for improving the health of all state residents by eliminating differences in disease, disability, and death rates among ethnic, racial and cultural populations. The office may provide grants for culturally appropriate health education demonstration projects and apply for, accept, and spend public and private funds for these projects. It also may recommend policies, procedures, activities and resource allocations to improve health among the state's racial, ethnic, and cultural populations.

The Connecticut Health Foundation (CHF) (http://www.cthealth.org) is the state's largest independent, non-profit grant-making foundation dedicated to improving the health of the people of Connecticut through systemic change and program innovation. After meeting with state agencies, community leaders, and health care professionals, the Foundation selected 3 program areas to focus its resources: Improving Access to Children's Mental Health Services; Reducing Racial and Ethnic

Health Disparities; and Expanding Access to and Utilization of Oral Health Services.

The Foundation's Policy Panel on Racial and Ethnic Health Disparities released its final report in March, 2005 which includes state policy recommendations that begin to address health disparities. Those recommendations specific to the Department of Public Health include:

- The Connecticut Department of Public Health should collect and integrate racial and ethnic health data into all of its statewide planning efforts and publish a biennial report on key findings from data collected on the health status of racial and ethnic populations.

- The Connecticut Office of Health Care Access and the Connecticut Department of Public Health should require health care organizations, including providers and payers, to collect data on each patient's primary language in health records and information systems, and post signage in the languages of the patients they serve.

- The Connecticut Department of Public Health should establish a certification program for all medical interpreters to ensure cultural competence and quality service.

- The Health Systems Regulations Bureau of the Connecticut Department of Public Health should establish a system for monitoring and enforcing the law regarding linguistic access in acute care hospitals (Public Act No. 00-119) and publish a report on its findings for public and legislative review.

- The Connecticut Department of Public Health should (a) collect and track data on the race and ethnicity of all licensed medical professionals and issue an annual report on the diversity of the health care workforce in the state and (b) require all health care professionals to participate in cultural and linguistic competence continuing education programs through licensure requirements.

- The State of Connecticut should allocate no less than $2.12 million of Connecticut's State Tobacco Settlement funds to specifically support evidence-based, culturally and linguistically competent health promotion programs that respond to the health needs of underserved racial and ethnic populations.

- The Connecticut Department of Public Health should match all available federal dollars allocated to the national loan forgiveness program each year; target these funds to attract a greater number of historically underrepresented students to the health professions; and promote the loan forgiveness program broadly and effectively.

F. Rural Health

The Connecticut definition of rural, adopted June 2004 by the ORH Advisory Board, uses the 2000 U.S. Census data and OMB designations. All towns in a designated Micropolitan Statistical Area with a population less than 15,000 and those towns in Metropolitan Statistical Areas with a population of less than 7,000 are designated rural for the State of Connecticut. Of the 169 towns in CT, there are 29 with populations of less than 7,000 (22). Specific concerns identified for rural Connecticut include: emergency medical services, transportation, recruitment and retention of adequate workforce, a decreasing social services safety-net, mental health, oral health, and others. The Primary Care Office (PCO), located in the Family Health Section has taken on a formal role in meeting with the staff of the Office of Rural Health, and PCO staff has recently been appointed to the ORH Advisory Board. The Title V program will continue to support the PCO and its collaborative efforts with the ORH and provide technical assistance to the ORH as they better assess and document the needs of the rural health community.

G. Other Vulnerable Populations

The Department has been interested in the health needs of vulnerable women and children, many of whom face barriers to care which are not addressed by the state's managed care system. These populations include the uninsured, single mothers transitioning from welfare to work, homeless

mothers and children, incarcerated women, adolescents who are concerned with confidentiality (parent involvement in their health care), immigrant and undocumented populations, infants who experience delays in newborn Medicaid eligibility determinations, and providers who are not prepared to deal with the multiple social and economic problems facing many of their patients. This is especially true in areas where hospital based clinics have closed and patients are referred to private practitioners.

Incarcerated Women's Health: The role of the Title V program has been to work collaboratively with other state agencies and community based organizations to address the issues of this vulnerable population. The DPH functioned as a conduit for bringing together key state agencies to address transitioning soon-to-be-released women, from York Correctional Institute, Connecticut's only female prison, back to the community healthy. As a result of this process, the DSS designated Medicaid eligibility workers to process Medicaid applications for inmates just prior to their release date. This is a model which can be replicated in the male correctional institutions throughout the state.

Homelessness: The DPH contracted with an independent public health consulting firm to assess and evaluate the health care access infrastructure for the Homeless population in order to enhance their access to health services. A statewide Homeless Health Advisory group, including governmental, public/non-for-profit, private, faith based, and advocacy organizations, was formed to guide this evaluation study. This study involved needs assessment of shelters, and their health care systems/infrastructure for the homeless population, and key informant interviews. The study is completed and the role of Title V is to identify and conduct intervention strategies to promote and enhance the health status of the homeless population.

Male Involvement: The FHS recognized that the health of fathers and men impacts the health of women, children and families. The role of Title V has been to become an active participant on the New Haven Family Alliance-Male Involvement Network and the DSS' Fatherhood Initiative Council to conduct population based activities by developing and disseminating consumer and provider educational materials regarding the importance of men's health and the impact on maternal and child health.

III. Health Priorities

A. MCH Priorities

In 2004, the Department invited a selected group of experts in the maternal and child health field in the State, including healthcare professionals, community advocates, and representatives from state agencies, to map out a perinatal health plan with priority goals for the State to address. This Statewide group adopted the following as a standard definition of perinatal health to guide efforts in the maternal and child health "comprehensive and integrative continuum of health care from the preconception period through the prenatal and postnatal periods. Care should be sensitive to ethnic and cultural diversity with an emphasis on the family and father involvement".

The Perinatal Advisory Group identified nine goals to address perinatal health. These goals include: 1. Reduce perinatal health disparities, particularly preterm/low birth weight births and infant and fetal mortality between and among racial and ethnic groups; 2. Improve access to a continuum of health care services for underserved and/or un-served women of child bearing age; 3. Enhance and encourage male involvement in the continuum of women's health care from preconception, prenatal through postnatal periods; 4. Reduce pregnancies and poor birth outcomes among adolescents; 5. Reduce unintended pregnancies for all women; 6. Reduce recognized birth-related risk factors for children with special health care needs; 7. Improve the state's system capacity to collect high quality maternal child health data and disseminate in a timely manner; 8. Improve access to mental health, substance abuse treatment and dental health services which can improve the overall health for pregnant and postpartum women; and 9. Improve inter-provider communication strategies regarding perinatal health care delivery. The Perinatal Advisory group will be reconvened to prioritize and provide guidance to the Title V program regarding the implementation of the nine identified goals and

objectives. This statewide perinatal strategy will provide the needed structure to better address the MCH federal and new state performance measures.

B. CYSHCN Priorities

The Children with Special Health Care Needs program includes the priority areas specific to this population in its program design. In order to enhance CSHCN services, the Family Health Section (FHS) within DPH has redesigned the program by requiring the Center to operate a program that is family-centered with family participation and satisfaction; performs early and continuous screenings; improves access to affordable insurance; coordinates benefits and services to improve access to care; participates in spreading and improving access to medical home and respite service; participates in developing a community-based service system of care, and promotes transition services for youth with special health care needs.

The Department has been leading the State in the implementation of the State Early Childhood and Comprehensive System's grant (SECCS). This initiative is called Early Childhood Partners (ECP) and the process brought together eight State agencies and statewide institutions, with extensive input from numerous community interests since October 2003 to create an outcome-driven Strategic Plan to support all Connecticut families to ensure that their children arrive at school healthy and ready to succeed. The strategic plan will be used as a framework for the operations of the newly established Children Cabinet by Connecticut legislators and Governor. The Plan aims at creating an integrated service system that incorporates comprehensive health services, early care and education, and family support and parent education to ensure the sound health and full development of all children. The system would provide for easy entry, clear navigation, and appropriate supports for all families and includes six priority goals for the State, which includes: 1. Every child, adolescent and pregnant woman in Connecticut will have access to comprehensive, preventive, continuous healthcare through a family-centered Medical Home; 2. All children will have access to affordable, quality early care and education programs and an effective transition to Kindergarten; 3. All parents will have access to the support and resources they need to raise healthy children; 4. Build the capacity for planning, resource allocation and monitoring of the early childhood services system through a collaborative local or regional early childhood structure for all Connecticut towns; 5. Create a state level infrastructure to guide, support, and monitor implementation of the Early Childhood Partners plan; and 6. Promote public education and public will through a broad communication and engagement strategy.

C. Data and MCH Impact

Consistent with the HP 2010 objectives, Connecticut gives priority to MCH surveillance through such activities as Pregnancy Related Mortality Surveillance, Child Health Profile (CHP) Database, DocSite for data management of Children and Youth with Special Health Care Needs (CYSHCN), Fetal and Infant Mortality Review, and Vital Records data collection and analysis, to name a few. The CHP is a database located in the FHS within DPH to hold information of newborns on lab screening tests, hearing tests, and birth defects reported by birth facilities through the electronic reporting system. The CHP is linked to Electronic Vital Records (EVR). The DocSite is a web-based system used by medical homes and regional medical home support centers to collect and report CYSHCN information to DPH. Emphasis is being placed on the necessity to develop better linkages among our many sources of data. All Title V activities and programs are designed to promote and protect the health of Connecticut's mothers, children and adolescents, and children with special health care needs.

There is growing emphasis on the development of data systems and linkages. Staff are coordinating the Memorandum of Understanding (MOU) between DPH and DSS regarding data exchanges. The purpose of this MOU is to improve public health service delivery and public health outcomes for low-income populations through the sharing of available Medicaid, HUSKY Plan Part B, HUSKY Plus and Title V data. The initial MOU included three addenda addressing the linkage of birth and Medicaid data, childhood lead screening and Medicaid data, and on Children Receiving Title V Services and Medicaid data. Linked data will be analyzed and used to guide MCH programs.

The need to strengthen data linkages was identified in the five-year needs assessment. The Title V program will be taking a lead role in securing a contract with the CT Hospital Association to obtain hospital discharge data. The acquisition of this data set will enhance case ascertainment for the maternal mortality surveillance program, enhance the Crash Outcome Data Evaluation System (CODES) database and provide additional data for the Asthma and other MCH programs both at the state and local levels.

In fall 2004, DPH executive staff expressed goals for improved and enhanced communications between and across programs that reduces barriers to effectiveness and efficiency across programs. To address these goals, the Virtual Child Health Bureau (VCHB) was formed. The VCHB is in the process of developing a Plan to coordinate its activities. With a special emphasis on child health, the VCHB has as its mission collaborations across branches within DPH to ensure optimum health of all children in the state. Within the VCHB, an interdepartmental group of database users and managers was formed called the VCHB Data Committee. The Data Committee now seeks to find meaningful ways to share child health information broadly across the Department. Using needs identified by staff across DPH, the Data Committee drafted a set of recommendations in spring, 2005, which may help guide its progress toward this goal. These recommendations need to be discussed, adopted and implemented. Some of these recommendations complement the state MCH priorities identified for the next five years.

IV. Conclusion

It is the role of Connecticut's Title V program, through funding of direct/enabling, population-based, and infrastructure building services, to address prioritized needs and gaps in services for the target populations. Community based programs are funded to provide direct and enabling services, such as case management and outreach. Population-based services include disease prevention, education, and the empowering of MCH populations about health and health related issues. Infrastructure building services include needs assessment, policy development, quality assurance, information systems development and management, and training that support individual, agency, and community health efforts.

The Title V Director utilizes various mechanisms to determine the importance, magnitude, value and priority of competing factors, which impact the MCH health services delivery in the State, which includes: 1. conducting ongoing statewide assessments (MCH five-year needs assessment, breastfeeding practices of African American women, bereavement services for families experiencing a fetal or infant death, Pregnancy Risk Assessment Tracking System [PRATS], Adolescent Health, Healthcare for the Homeless, CYSHCN Needs Assessment, etc.); 2. reviewing and analyzing Title V programs quarterly reports submitted by all contractors, which includes both quantitative and qualitative information. This information is reviewed and provides valuable input into MCH programming, as well as serving as a vehicle for identifying and documenting emerging MCH issues; 3. conducting quarterly technical assistance meetings with the MCH contractors (i.e., FIMR, RFTS, etc.). This provides an additional opportunity for contractors to share information with Title V program staff and their colleagues regarding MCH issues that they are facing as community-based providers of services. Other external factors, which cannot be overlooked and impact the importance of MCH service delivery, and MCH programming have been previously discussed (economy, insurance status, legislation, etc.). The combination of the ongoing assessments, quarterly reporting data, technical assistance meetings and site visits, as well as other sources, assists the Title V Director in addressing the MCH needs and determining priorities for the State.

Please refer to the attachment to this section for all Tables and Figures, and for Works Cited.

B. AGENCY CAPACITY

Authority for the Maternal, Infant, and Child and Adolescent Health Programs is derived from the CT General Statutes and Title V Federal Grant Program Requirements. The following describes the statutes that support DPH authority for MCH programs.

Sec. 4-8(1949) Qualifications, Powers and Duties of Department Head. This statute authorizes the transfer of Title V funds to the Department of Social Services (DSS).

Sec 14-100a PA 05-58 (2005) Child Restraint systems. The former infant/child seat belt law was amended to address rear-facing child seats, use of booster seats, and increase the minimum age to six years old. The injury prevention program is impacted by this statute.

Sec. 10-206.PA 04-221(1940-2004) Health assessments. Each local or regional board of education shall require each pupil enrolled in the public schools to have health assessments conducted by a legally qualified practitioner of medicine, an advanced practice registered nurse or registered nurse, a physician assistant, or by the school medical advisor. The assessment includes: a physical examination; chronic disease assessment (i.e., asthma, lead levels), an updating of immunizations; and vision, hearing, speech and gross dental screenings. The assessment also includes tests for tuberculosis, sickle cell anemia or Cooley's anemia.

Sec 19a-2a PA 93-381(1993) Powers and duties. The Commissioner of DPH shall employ the most efficient and practical means for the prevention and suppression of disease and shall administer all laws under the jurisdiction of DPH and the Public Health Code. He shall have responsibility for the overall operation and administration of DPH. All Title V Programs are impacted by this statute.

Sec. 19a-4j PA 98-250(1998) Office of Multicultural Health. The responsibility of the office is to improve the health of residents by eliminating difference in disease, disability and death rates among ethnic, racial and cultural populations. All Title V Programs are impacted by this statute. Although the Office was eliminated through layoffs in January 2003, activities continued and the Office was officially re-established April 2005.

Sec. 19a-4i PA 93-269(1993) Office of Injury Prevention. This office coordinates and expands prevention and control activities related to intentional and unintentional injuries, including surveillance, data analysis, integration of injury focus within DPH, collaboration, support and develop community based programs and develop sources of funding. This statute impacts many Title V Programs since injury is the leading cause of death for the 1 to 19 years old age population.

Sec. 19a-7 PA 75-562(1975) Public Health Planning. DPH shall be the lead agency for public health planning and shall assist communities in the development of collaborative health planning activities. All Title V Programs are impacted by this statute.

Sec. 19a-7a PA 90-134(1990) State goal to assure the availability of appropriate health care to all state residents. The goal of the state is to assure the availability of appropriate health care to all residents, regardless of their ability to pay. All Title V programs are impacted by this statute.

Sec. 19a-7c PA 90-134(1990) Subsidized non-group health insurance product for pregnant women. DPH with DSS may contract to provide a subsidized non-group health insurance for pregnant women who are not eligible for Medicaid and have incomes under 200% of the federal poverty level. Health Start, Comadrona, Family Planning, Community Health Centers (CHCs) are the programs most affected by this statute.

Sec. 19a-7f PA 91-327(1991) Childhood immunization schedule. An immunization program shall be established by DPH, cost of vaccine will not be a barrier to age-appropriate vaccination. CHCs and School Based Health Centers (SBHCs) are the programs most affected by this statute.

Sec. 19a-7h PA 94-90(1994) Childhood immunization registry. The registry shall include information to accurately identify a child and to assess current immunization status. CHCs and SBHCs are the

programs most affected by this statute.

Sec. 19a-7i PA 97-1(1997) Extension of coverage under the Maternal and Child Health Block Grant. DPH shall extend coverage under Title V of the Social Security Act to cover underinsured children with family incomes between 200% -300% of the federal poverty level. If allowed by federal regulations, such expansion may be included for reimbursement under Title XXI of the Social Security Act. CSHCN Centers are the programs most affected by this statute.

Sec. 19a-17b, PA76-413(1976) Peer Review: Definitions, immunity; discovery permissible from proceedings. There shall be no monetary liability against any person who provides testimony, information, records, etc. The proceedings of a medical review committee are not be subject to discovery or introduction into evidence in any civil action for or against a health care provider arising from matters subject to evaluation and review by such committee. Fetal and Infant Mortality Review (FIMR) and Pregnancy Related Mortality Surveillance are the programs most affected by this statute.

Sec. 19a-25 PA 61-358(1961) Confidentiality of records procured by DPH or directors of health of towns, cities or boroughs. Describes the restricted use and confidentiality of all information, records of interviews, written reports, statements, notes, memoranda or other data procured by DPH or its representatives for the purpose of reducing the morbidity or mortality from any cause shall be used solely for the purposed of medical or scientific research and for disease prevention and control. All programs are influenced by this statute. FIMR and Pregnancy Related Mortality Surveillance are the programs most affected.

Sec. 19a-32(1949) Department authorized to receive gifts. DPH is authorized to receive, hold and use real estate and to receive, hold, invest and disburse money, securities, supplies or equipment offered it for the protection and preservation of the public health and welfare by the federal government or by any person, corporation or association, provided such assets shall be used only for the purposes designated. All Title V Programs are impacted by this statute.

Sec. 19a-35 PA 35-240(1935) Federal funds for health services to children. DPH is designated as the state agency to receive and administer federal funds which may become available for health services to children. Title V Programs serving children are most affected by this statute.

Sec.19a-48(1949) Care for Children with Cerebral Palsy. DPH shall furnish services for children who have cerebral palsy including locating the children, providing medical, surgical, corrective and allied services and care, and providing facilities for hospitalization and aftercare. CYSHCN programs are most affected by this statute.

Sec.19a-49(1961) Services for Persons with Cystic Fibrosis. DPH shall establish and administer a program of services for children and adults suffering from cystic fibrosis programs. CYSHCN programs are most affected by this statute.

Sec. 19a-38. PA 156(1965). Fluoridation of public water supplies. Wherever the fluoride content of public water supplies serving 20,000 or more persons supplies less than 8/10ths of a milligram per liter of fluoride, whoever has jurisdiction over the supply shall add a measured amount of fluoride so as to maintain the fluoride content. The Oral Health program is affected by this statute.

Sec. 19a-50 PA 39-142 PA 37-430(1937 & 1939) Children crippled or with cardiac defects. DPH is designated to administer a program of services for children who are crippled or suffering from cardiac defect and to administer federal funds which may become available for such services. CSHCN programs are most affected by this statute.

Sec.19a-51 PA 63-572(1963) Pediatric Cardiac Patient Care Fund. There shall be a Pediatric Cardiac Patient Care Fund to be administered by DPH and to be used exclusively for medical, surgical, preoperative and postoperative care and hospitalization of children, residents, who are or may be patients of cardiac centers in this state. CYSHCN programs are most affected by this statute.

Sec. 19a-52(1981) Purchase of equipment for handicapped children. DPH may, purchase wheelchairs and placement equipment directly. CYSHCN programs are most affected by this statute.

Sec. 19a-53 PA 33-318(1933) Reports of physical defects of children. Each health care provider who has professional knowledge that any child under 5 years of age has any physical defect shall mail to DPH a report stating the name and address of the child, the nature of the physical defect and such other information. The CSHCN Registry is supported by this statute.

Sec. 19a-54 PA 33-266(1933) Registration of physically handicapped children. Each institution supported in whole or in part by the state shall report to DPH, the name and address of each child under 21 years of age who is physically handicapped for whom application is made for admission, whether such child is admitted or rejected. The CSHCN Registry is supported by this statute.

Sec. 19a-55 PA 65-108(1965, 2002) Newborn infant health screening. Each institution caring for infants shall cause to have administered to every infant in its care an HIV-related test, and a series of tests for disorders as listed in the attachment to this section. This bill has been amended to expand testing, as listed in the supporting document attached.

Sec. 19a-56a PA 89-340(1989) Birth defects surveillance program. The program shall monitor the frequency, distribution and type of birth defects occurring in CT on an annual basis. DPH shall establish a system for the collection of information concerning birth defects and other adverse reproductive outcomes. The CSHCN Registry is supported by this statute.

Sec. 19a-56b PA 89-340(1989) Confidentiality of birth defects information. All information collected and analyzed pursuant to section 19a-56a shall be confidential insofar as the identity of the individual patient is concerned and shall be used solely for the purposes of the program. The CSHCN Registry is supported by this statute.

Sec 19a-59 PA 81-205(1981) Program to Screen Newborn Infants for Hearing Impairment at Birth. Each institution that provides childbirth service will include a universal newborn hearing screening program as part of its standard of care and establish a mechanism for compliance review. DPH will establish a plan to implement and operate a program of early identification of infant hearing impairment. Newborn Hearing Screening Program is supported by this statute.

Sec. 19a-59a PA 82-355(1982) Low Protein modified food products and amino acid modified preparations for inherited metabolic disease. DPH may purchase prescribed special infant formula, amino acid modified preparations and low protein modified food products directly. CYSHCN programs are supported by this statute.

Sec. 19a-59b PA 83-17(1983) Maternal and Child Health Protection Program (MIHPP). DPH shall establish a maternal and child health protection program to provide outpatient maternal health services and labor and delivery services to needy pregnant women and child health services to children less than 6 years of age. Comadrona, Right from the Start, and Healthy Start are supported by this statute.

Sec. 19a-59c PA 88-172(1988) Administration of federal Special Supplemental Food Program for Women, Infants and Children in the state. DPH is authorized to administer the WIC program in the state, in accordance with federal law and regulations. WIC is supported by this statute.

Sec. 19a-60 PA 45-462(1945) Dental services for children. DPH may furnish dental services for children free of charge where the cost of necessary service would be a financial hardship to their parents. CHCs and SBHCs are affected by this statute.

Sec. 19a-90 PA 41-255(1941) Blood tests of pregnant women for syphilis. Each physician giving prenatal care to a pregnant woman in this state shall take a blood sample within 30 days from the

date of the first examination and during the final trimester, and shall submit such sample for a standard serological test for syphilis. Family Planning, CHCs and SBHCs are affected by this statute.

Sec. 19a-110 PA 71-22(1971) Report of lead poisoning. Defines reporting requirements to DPH regarding blood lead levels equal to or greater than 10 micrograms per deciliter of blood or any other abnormal body burden of lead. CHCs and SBHCs are affected by this statute.

Sec.19a-62a(2000) Pilot program for early identification and treatment of pediatric asthma. DPH, with DSS, shall establish pilot program for the early identification and treatment of pediatric asthma. The DPH Asthma Program is impacted by this statute.

CSHCN Program Capacity in CT

The CSHCN program provides care coordination, advocacy and family support to CYSHCN regardless of enrollment financial status. A review of the CYSHCN program resulted in a new infrastructure and capacity building strategy to meet the Healthy People 2010 goals of parent partnership, comprehensive care within a medical home, adequacy of insurance, screening for special needs, community-based service system and transition to all aspects of adult life. The CSHCN/Regional Medical Home Support Centers (RMHSCs) are responsible for providing services to children receiving Supplemental Security Income (SSI) benefits who meet program eligibility criteria. The 5 centers are The Stamford Health System serving Southwest CT, Yale School of Medicine, serving South Central CT, St Mary's Hospital serving Northwest CT, LEARN serving Eastern CT and Charter Oak Health Center serving North central CT.

The RMHSCs will enhance the capacity for medical homes in the region to screen children and assist the medical homes through community-based health care systems. There are an estimated total of 120,000 CYSHCN in CT. The second purpose of the RMHSCs is to improve availability of programmatic and health care service data on CYSHCN for evaluation and development of quality programs. Data and practice management for this new approach will be supported through Doc Site, a quality assurance web-based program. Multi-state agency Memoranda of Understanding (MOUs) will be utilized to support care coordination and data sharing on CYSHCN.

Care Coordination, the core of both the RMHSCs and the medical homes will be technically supported to assure that there is an inter-agency collaboration in meeting the needs of the CYSHCNs. RMHSCs will also support families with community-based resources, family networking and building parent partnerships in medical homes. Funds for durable medical equipment, prescriptive medications, special nutritional formulas and respite care needs for the uninsured and underinsured families are available on a limited basis.

Regional Family Networks (RFN) will be groups of parents and/or caregivers of CYSHCN whose primary responsibilities within this system include family support services and quality assurance for the service delivery system. RFN will serve as an additional support to the care coordinators within the RMHSCs on family-centered training and capacity building.

A CT Medical Home Learning Collaborative resulted from participation in the National Institute of Child Health Quality's (NICHQ) Medical Home Learning Collaborative with the purpose of improving care for CYSHCN by implementing the AAP's Medical Home concept. The collaborative meets quarterly and is open to all providers interested in building their capacity as a medical home, especially in meeting the needs of CYSHCN. A Medical Town News is published quarterly by DPH and posted on DPH's website: www.dph.state.ct.us/bch/Family%20Health/cyshcn/cyshcn-medical%20home%20site.htm.

The United Way's INFOLINE (211) Child Development Infoline (CDI) is the primary intake source for CYSHCN. CDI caseworkers assess the caller's situation, and make referrals to CT Birth to 3 System, Help Me Grow, Preschool Special Education, and/or CSHCN/RMHSC. The 211 component of Infoline, funded as CT's Maternal and Child Health Information and Referral Service, will work closely

with the RMHSCs on their resource information updates.

Title V Partnership Programs for Pregnant Women, Mothers and Infants

Breastfeeding Initiative: Initially funded through the SSDI Initiative and in-kind support, staff are working to develop internal mechanisms and evaluate the DPH's capacity to collect population based breastfeeding data. As a result of these efforts, in January 2004 the Electronic Newborn Screening Database started to collect data from all birthing hospitals on the mother's intent to breastfeed.

Comadrona: DPH contracts with the Hispanic Health Council of Hartford to provide culturally appropriate intensive case management services to pregnant Latina and African-American women and their children who reside in the greater Hartford area.

Family Planning: Through its contract with Planned Parenthood of CT, Inc., comprehensive reproductive health services are available in 15 locations across the state. Family Planning promotes decreasing the birth rate to teens age 15-17, preventing unintended pregnancy, and increasing access to primary reproductive health care.

Fetal and Infant Mortality Review (FIMR): Six high-risk communities are funded to examine confidential, de-identified cases of infant deaths, with a goal of understanding how local social, economic, public health, educational, environmental and safety issues relate to infant deaths in order to improve community resources and service delivery. To complement and expand the FIMR process, Perinatal Periods of Risk will be introduced next year.

Healthy Choices for Women and Children (HCWC): HCWC provides intensive case management services to low income, pregnant and postpartum women who abuse substances or are at risk for abusing, or whose partner abuses substances, and their children from birth to age 3, who reside in the city of Waterbury or surrounding communities. Referrals and linkages to community-based health and health related services are provided.

Healthy Start: This statewide collaboration between DSS and DPH aims to reduce infant mortality, morbidity and low birthweight, and to improve healthcare coverage and access for children and eligible pregnant women. Last year, DPH signed a collaborative agreement with the Federal New Haven Healthy Start Program and several priorities emerged as common concerns: Male Involvement; MCOs; Care Coordination; Consortium Development; FIMR/PPOR; and Data Collection.

Maternal and Child Health Information and Referral Service (MCH I&R): DPH contracts with the United Way of CT to administer the toll-free MCH hotline that provides information on health and related services. Services are accessible to non-English speaking callers and to speech/hearing impaired callers. More information on INFOLINE is noted above.

Oral Health: The Office of Dental Public Health has a comprehensive public health strategy for the prevention of oral diseases and disorders in CT's children and their families. The Office works with the American College of Obstetrics and Gynecology and the March of Dimes to address oral health during the prenatal period, and has partnered with DSS to implement a Dental Loan Repayment Program for dentists and hygienists to work in underserved areas of the state. Work is currently underway to develop a new state oral health plan.

Pregnancy Related Mortality Surveillance (PRMS): An OB-GYN consultant conducts maternal mortality reviews and based on findings, provides education to medical providers to prevent future maternal deaths.

Right from the Start (RFTS): Located in four communities, the RFTS program provides intensive case management services to pregnant and/or parenting teens. Services provided by community-based contractors must include: intensive case management; outreach and case-finding activities; promotion of breastfeeding; integration of the USPHS/Smoke Free Families Smoking Cessation Intervention

model; and public awareness activities. Services must be comprehensive, culturally appropriate, community-based and family centered.

Sudden Infant Death Syndrome (SIDS): In previous years, DPH provided bereavement services to families statewide who experienced a sudden infant death, based on referrals from the Office of the Chief Medical Examiner. Services included home visits, referrals to community-based services, and follow-up. A statewide assessment of cultural appropriateness of bereavement services is currently being conducted. Upon completion, MCHBG funding will be allocated to expand access to and awareness of bereavement services for fetal and infant mortality, including SIDS events.

SSDI: CT is focusing on 3 main activities: assess and enhance programmatic data collection systems in order to improve DPH's ability to report on the many required outcome measures; expand the linkage of the Birth and Supplemental Nutrition Program for Women, Infants and Children (WIC) to include a linkage with the state Medicaid eligibility files; and develop and evaluate a database for community-based providers who participate in the CSHCN Medical Home Learning Collaborative.

The Injury Prevention Program: In collaboration with its many partners, the program provides resource materials, and technical assistance on injury prevention issues for Title V funded programs and other community service providers. The Program also facilitates the Interagency Suicide Prevention Network.

Title V Partnership Programs for Children and Adolescents, Age 1 through 22 years.

Comadrona: As described above.

Healthy Start: As described above.

School Based Health Centers (SBHC): DPH funds 63 SBHCs in 18 communities, serving students in grades pre-K-12. SBHCs are licensed as outpatient facilities or hospital satellites. They offer services addressing the medical, mental and oral health needs of youth, including crisis intervention, health education, social services, outreach, and substance abuse prevention services.

Expanded School Health Services (ESHS): DPH funds 2 ESHS projects. One sites focuses on preventing and improving mental health status and service referral for children and youth in a regional school system and one site provides access of physical and behavioral health services to preschool aged children and families who are at risk for learning in one community.

Family Planning: A special effort is made to target services to teens and provide STD screening and treatment, HIV/AIDS screening, and contraception services. Other services include free pregnancy tests and counseling for adolescents at or below 150% federal poverty level, outreach efforts at health fairs, teen life conferences, and statewide events to provide reproductive health and STD prevention literature, as well as conducting community educational programs to teens at risk.

Healthy Choices for Women and Children (HCWC): As described above.

Maternal and Child Health Information and Referral Service (MCH I&R): As described above.

Oral Health: DPH funds 6 School Based Programs to improve dental access and services underserved children as well as conduct ongoing surveillance for planning purposes of dental health status of youth through the CT BRFSS.

Right from the Start: As described above.

The Early Childhood Partners (ECP): The ECP Comprehensive Systems Plan aims to create an integrated service system that incorporates comprehensive health services, early care and education, family support and parent education to ensure the sound health and full development of children. A

technical blueprint for the CT Early Childhood Cabinet is currently pending before the legislature and could be created through an Executive Order. The Cabinet will include the Commissioners of the departments with primary responsibility over early childhood services.

The Injury Prevention Program: The CT Young Worker Safety Team, a collaboration of DPH and State Departments of Labor and Education, federal and local agencies, promotes safety of adolescents in the workplace through awareness, education and training activities. The Program, in collaboration with partners to facilitates the Interagency Suicide Prevention Network and participates in the Youth Suicide Advisory Board.

Title V Partnership Programs for Children with Special Health Care Needs

Children With Special Health Care Needs (CSHCN): Children who are screened for special health care needs and are either uninsured or underinsured may be eligible for durable medical equipment, prescriptive pharmacy and special nutritional formulas. The CSHCN program also offers a limited respite program based on available funds, and transition services to adult care.

Adult and Maternal Phenylketonuria Program (PKU): The 2 Regional Genetic Treatment Centers (at UConn Health Center and Yale) maintain current records on all adolescent and adult females in CT with PKU, and serves as genetics consultants for primary care providers throughout the state. Genetic and nutritional counseling and high-risk pregnancy care is provided to adolescent and adult females in CT with PKU.

Genetics: The 2 Regional Genetic Treatment Centers provide access to genetic services for all residents. These services include confirmation testing for newborns identified with abnormal metabolic screening results, prenatal testing, genetic counseling, and ongoing treatment, support for adults with PKU, and high risk pregnancy care for the maternal PKU clients. See the attachment to this section for the list of CT Newborn Screening Panel Disorders.

Pregnancy Exposure Information Services (PEIS): PEIS provides information and referral services via a statewide toll-free telephone number to pregnant women and health care providers concerning the potential teratogenic effects of drugs, maternal illness, and occupational exposure.

Sickle Cell Program: The 2 State funded Regional Sickle Cell Programs, located at Yale University and CCMC, provide comprehensive care programs that include confirmation testing, counseling, education and treatment for newborns identified with hemoglobinopathies through the NBS program. The Sickle Cell Disease Association of America located in New Haven and Hartford serves youth with transition to adult health providers and provides educational programs to increase community awareness. The Southern Regional Sickle Cell Association enhances testing, counseling, case management in the Southwest region of CT.

Universal Newborn Screening: The statewide Universal Newborn Screening (UNBS) program is a population-based program to test, track and treat all newborns. All newborns are screened for the disorders as listed in the document attached to this section, "CT Newborn Screening Panel." Infants with abnormal screening results are referred for comprehensive testing, counseling, education, and treatment services. The program provides increased public health awareness of genetic disorders, public health education, and referrals.

Universal Newborn Hearing Screening (UNHS): All 30 birthing facilities in the state implemented a UNHS program. Standardized equipment is used to screen all newborns prior to discharge. Hospital staff notify the primary care providers of all infants who are in need of follow-up audiologic testing. Tracking and follow-up of children are conducted at the state level. A web-based reporting system tracks screening results from the birth hospitals. A database is used to track infants referred to audiologists for further evaluation. Those with hearing loss are enrolled in the CT Birth to 3 Program.

Oral Health: The Office of Dental Public Health addresses the oral health needs of CYSHCN through

health promotion activities, particularly early childhood caries prevention. Oral health promotion and disease prevention is an integral part of the goals, objectives and educational activities of the CSHCN program.

School Based Health Centers: SBHCs provide primary and preventive physical and behavioral health care to CYSHCN who are mainstreamed in school settings. In such cases, they coordinate the care they provide with a child's primary and specialist caregivers, and provide support while the child is in school.

Cultural Competency

The Office of Multicultural Health was re-established in April 2005. Cultural Competence language is standard for Title V funded contracts as of July 1, 2003. The FHS staff remain committed to addressing cultural competency during site visits to contractors and staff has developed a assessment tool to assure that our contractors are providing culturally appropriate services containing key items to be discussed during a site visit. A check box on DPH's Site Visit Monitoring Tool reminds staff to discuss and address cultural competency during site visits.

DPH is presently working with a consultant to assess and evaluate breastfeeding initiation and duration rates of African American and Black women in CT. This consultant will make recommendations to the DPH on ways to improve these rates. DPH collaborated with the CT Breastfeeding Coalition (CBC) to develop and produce a document in English and Spanish describing the breastfeeding laws in CT. This document is mailed to all new mothers in CT.

DPH continues to address the health care needs of CT's homeless population by implementing activities outlined in the Healthcare for the Homeless Strategic Plan. DPH has provided funding to 10 CHCs to enhance and strengthen the infrastructures and linkages with homeless shelters while enabling the center's ability to effectively address the healthcare needs of CT's homeless population. The CT Youth Health Service Corp., a program co-funded by DPH and AHEC which prepares high school youth for careers in the health care field, includes a module in its curriculum regarding working with the homeless population and a module on cultural competency.

C. ORGANIZATIONAL STRUCTURE

Governor M. Jodi Rell has been serving as CT's Governor since July 2004. Dr. J. Robert Galvin, DPH Commissioner since December 2003, serves as the leading health official in CT and advisor to the Governor on health-related matters. Dr. Galvin brings experience in the fields of medicine and public health, as well a strong commitment to serving the people of Connecticut.

DPH is the center of a comprehensive network of public health services, and is a partner to local health departments for which it provides advocacy, certification and training, technical assistance, consultation and specialty services. DPH is a source of health information used to monitor the health status of CT's residents, set health priorities and evaluate the effectiveness of health initiatives. The agency is a regulator of the health community, focusing on health outcomes while maintaining a balance between health status and administrative burden. DPH works to prevent disease and promote wellness through community-based education and programs.

As a result of agency-wide focus groups and strategic planning workshops conducted in late 2004, DPH was reorganized and is now comprised of eight Branches. The Oral Health Program, previously located in the Family Health Section, is now the Office of Dental Public Health and is under the auspices of the Deputy Commissioner. The majority of the Title V activities are located in the Public Health Initiatives (PHI) Branch and a detailed description follows:

Within the Public Health Initiatives Branch, led by Richard Edmonds, MA, Lisa Davis, RN, BSN, MBA

serves as the Section Chief of the Family Health Section (FHS) and as the Title V Director. The majority of CT's Title V program activities reside organizationally within the FHS of the PHI Branch, however, other MCH related programs such as oral health, nutrition, childhood lead poisoning prevention, diabetes, tobacco, obesity prevention and asthma are located organizationally in other Sections within the Public Health Initiatives Branch. Other Branches within DPH work cooperatively with Title V funded programs and provide support to programs that promote maternal and child health in the state of CT. For example, in the Laboratory Branch staff analyzes blood specimens from newborns for genetic screening. In the Planning Branch, Health Information Systems and Reporting Section, under the direction of Julianne Konopka, vital record data bases containing information on births, deaths, hospitalizations and risk factors related to maternal and child health are maintained. Epidemiologists within this branch use vital record information to help direct and evaluate Title V program activity.

The Family Health Section has identified their mission as "improving the health of CT's resident across the lifespan through culturally appropriate surveillance, public education, family-centered interventions and community-based capacity building." FHS's core purpose is "to optimize the health of families" with a vision that "all individuals and families achieve optimal health through appropriate and comprehensive health services." FHS will develop crucial business alliance and work with both internal and external stakeholders as partners to optimize the health of families.

The Family Health Section is comprised of three units: Women, Men, Aging & Community Health (WMACH); Child, Adolescent & School Health; and Epidemiology and Injury Prevention. Programs within each unit are defined in the Other (MCH) Capacity section of this report. This structure enables the FHS to focus on and improve the health status of individual members of a family as a cohesive unit. The WMACH unit primarily focuses on the adult members of a family and their public health primary care access point, however, safety net providers such as the CHCs, provide services to clients throughout the entire lifespan. The Child, Adolescent & School Health unit focuses on the pediatric and adolescent members of a family and their public health primary care access point. The SEQA unit is structured to focus on supporting the programs with necessary data analyses and program evaluation to track and measure results and ultimately assure that identified objectives are attained and provide quality care/services to Title V clients.

The Office of Dental Public Health is organizationally located outside of the PHI Branch and reports directly to the Deputy Commissioner. Dr. Ardell Wilson, DDS, MPH has been designated as the State Oral Health Director and is responsible for the Office of Dental Public Health. Although organizationally in a different area within DPH, a strong collaborative relationship exists with the MCH programs.

Sharon Tarala, RN, JD is the Supervising Nurse Consultant of the WMACH unit. Staff within this unit work on the following programs: CT Youth Health Service Corp, Comadrona, CHCs, Family Planning, FIMR Program, Healthy Choices for Women and Children, Infant Mortality Bereavement Services, Intimate Partner Violence, MCH Referral and Information Services, Pregnancy Related Mortality Surveillance, Primary Care Office, Right from the Start, and Sexual Assault Prevention and Intervention.

Dorothy Pacyna, MS, RN is the Supervising Nurse Consultant of the Child, Adolescent & School Health Unit. The programs served by these staff are: Abstinence Only Education, Expanded School Health Services, SBHCs, Children and Youth with Special Health Care Needs, Genetics Services, Maternal PKU, Pregnancy Exposure Information Service, Sickle Cell Services, Sickle Cell Transition Program, Universal Newborn Hearing Screening, Universal Newborn Screening, Early Childhood Partners Program and Family Advocacy.

Marcia Cavacas, MS, Epidemiologist 4, is the supervisor for the Epidemiology and Injury Prevention Unit. Programs in this unit include the Child Health Access Project, Crash Outcome Data Evaluation System (CODES), Statewide Systems Development Initiative (SSDI), the Children with Special Health Care Needs Registry, and the Injury Prevention Program.

Coordination of the development of the Title V Block Grant is supervised by Julianne Konopka, Section Chief of the Health Information Systems and Reporting (HISR) Section in the Planning Branch. It is a collaborative effort between the FHS and the HISR Section on all aspects of the Block Grant Application and Annual Report development. Also under the supervision of Julianne Konopka is the State Office of Vital Records. Epidemiologists within this Section use vital records information to help direct and evaluate Title V program activity and also provide epidemiological support to the FHS and Title V programs.

Resumes are included as Supporting Documents and are on file at DPH for Lisa Davis, Marcia Cavacas, Dorothy Pacyna, Sharon Tarala, and Julianne Konopka. DPH Organizational charts are attached to this section and included in the Supporting Documents Section.

D. OTHER MCH CAPACITY

The Department is comprised of eight Branches, a new organizational structure as a result of agency-wide focus groups and strategic planning workshops in late 2004 and implemented February 2005. Within the Public Health Initiatives (PHI) Branch, led by Richard Edmonds, MA, Lisa Davis, RN, BSN, MBA serves as the Director of the Family Health Section (FHS) and as the Title V Director. Robin Lewis provides secretarial support to the Ms. Davis. The majority of CT's Title V program activities reside organizationally within the FHS in the PHI Branch.

Sharon Tarala, RN, JD was recently promoted to Supervising Nurse Consultant and is now responsible for the Women, Men, Aging & Community Health Unit. Staff within this unit include Nurse Consultants Donna Fox, RN, MA, and Anthony Mascia, MSN, RN. Additional staff include Health Program Associates Marilyn Binns, Felicia Epps and Veronica Korn. These staff work on the following programs: Comadrona, Community Health Centers, Family Planning, Fetal and Infant Mortality Review, Healthy Choices for Women and Children, Intimate Partner Violence, MCH Referral and Information Services, Pregnancy Related Mortality Surveillance, Right from the Start, Sexual Assault Prevention and Intervention.

Within the Child, Adolescent and School Health Unit, The CYSHCN program is supervised by Dorothy Pacyna, RN and includes Epidemiologist Chun-Fu Liu, and Health Program Associates Robin Tousey-Ayers and Ann Gionet. Ms. Gionet also serves as a Family Advocate, and works closely with staff to provide support for all areas of the Medical Home System with focus on the respite component, the Regional Family Support Network (RFSN). She also provides consultation to staff regarding family issues, participates in the development and review of appropriate program policies to ensure that a family-centered, culturally competent perspective is maintained. The Newborn Screening program in this unit, led by Vine Samuels, includes Nurse Consultants Fay Larson, RN, MSHA, Donna Maselli, RN, BS, MPH and Dotti Trebisacci, RN as well as Health Program Associate Shi-Yu Kettering and Health Program Assistant Amy Olrongly. The School and Adolescent Health Program in this unit, led by Barbara Pickett, includes Nurse Consultants Donna Heins, RN, BS, MPH and Regina Owusu, RN, BSN, MPH; Health Program Associate Linda Durante Burns and Nutrition Consultant Charles Slaughter. Rose Marie Mitchell provides secretarial support to the unit. The programs served by this entire unit are: Abstinence Only Education, Expanded School Health Services, School Based Health Centers, Children and Youth with Special Health Care Needs, Genetic Services, Maternal PKU, Pregnancy Exposure Information Services, Sickle Cell Services, Sickle Cell Transition, Universal Newborn Screening (metabolic and hearing). Kevin Sullivan, Health Program Associate, is responsible for coordinating the CT Early Childhood Comprehensive Systems (Early Childhood Partners, ECP) program.

Marcia Cavacas has been promoted to Epidemiologist 4 and serves as the supervisor of the Epidemiology and Injury Prevention Unit. Clerical support is provided by Jacqueline Douglas. Epidemiologists Carol Stone, PhD., and Jennifer Morin, MPH support programs across FHS. Social

Worker Meryl Tom and Health Program Associates Marian Storch and Margie Hudson also serve programs in the unit including Child Health Access Project, Statewide Systems Development Initiatives (SSDI), Children with Special Health Care Needs Registry, CODES and injury prevention activities. This unit is currently recruiting for two Title V-funded Epidemiologist 2 positions.

Dr. Ardell Wilson, DDS, MPH has been designated as the State Oral Health Director and is responsible for the Office of Dental Public Health. Recruitment continues for staffing to support the activities conducted by this Office.

Within the Planning Branch, the Health Information Systems and Reporting Section, support through the preparation of the MCHBG application is provided. Also, Epidemiologists Diane Aye, MPH, PhD, Marijane Mitchell, MS, Celeste Jorge, BA, and Associate Research Analyst Federico Amadeo, MPA provide epidemiologic support to FHS programs and through their work on other programs such as the Connecticut School Health Survey, Health Professional Shortage Areas, and Vital Statistics.

Within the Administrative Branch, support to Title V programs is given by the Contracts Management Division and Fiscal Services. At the State Public Health Laboratory, Lab Assistant Leslie Mills offers support to the Newborn Screening program.

Resumes are on file at DPH for Lisa Davis, Dorothy Pacyna, Marcia Cavacas, Sharon Tarala, and Julianne Konopka, and can be found in the Supporting Documents section.

E. STATE AGENCY COORDINATION

CT's Title V Program has established working relationships with the organizations found in the document attached to this section. Because of the diverse programs funded by the Block Grant, DPH works with other state agencies and within its own programs to insure coordination of services. Please see the Attachment to this section for a listing of all organizations. The narrative below describes the most important of those collaborations.

Abstinence-Only Education program staff work closely with School Based Health Centers (SBHCs), the CT Association of Schools, and other State and local agencies and organizations affected by the project, including CYSHCN Program, STD Program, AIDS Program, SDE, DSS, DCF, and OPM. Staff coordinate with representatives of Network CT, a SPRANS community-based abstinence education grantee, to share information and resources, including but not limited to peer mentors and counselors, parent/guardian outreach activities, and public awareness activities, such as radio spots, program brochures and posters.

The CYSHCN program collaborates with the Social Security Administration/Disability Determination Unit at DSS to identify and refer potential enrollees to the Program. CYSHCN program staff also network with the Bureau of Rehabilitation Services at DSS regarding the provision of occupational services to youth transitioning to adulthood.

Staff from DPH and the CYSHCN Regional Centers participate on: DCF Advisory Committee for Medically Fragile Children in Foster Care, DMR's Birth to 3 Public Awareness and Medical Advisory Committee and Interagency Coordinating Council (ICC), and the legislatively mandated Family Support Council.

Memoranda of Understanding are being draft by DPH with multiple state agencies (DSS, DMR, DCF, SDE). Through these agreements, the parties intend to recognize their shared goals and to establish methods of coordination and cooperation to ensure that CYSHCN and their families/caregivers who are served by the Regional Medical Home Support Centers (RMHSC) receive timely and comprehensive health care services.

DPH joined in partnership with United Way of CT/2-1-1 Infoline, DMR (Birth to 3), and the Children's Trust Fund (Help Me Grow) supporting the CDI to serve as the centralized point of entry for all CYSHCN in a system of care. CDI will develop and implement a referral and coordination of services model to assess and refer appropriate CYSHCN to Birth to 3, Ages and Stages, Help Me Grow and a local RMHSC.

DPH, through its partnership with the CHDI, contracted with AHEC to develop and implement a Medical Home Academy (MHA) for pediatric physicians, nurses, other allied health professionals, and families. The CT MHA was introduced as one full-day Medical Home Implementation Conference on March 8, 2005.

DPH and the CT Lifespan Respite Coalition, Inc. (CLRC) have partnered to create a two-section "Get Creative About Respite" manual. To determine the importance of respite services and provide information to families in the state, DPH conducted a needs assessment and found the top 5 gaps included planned respite, emergency respite, after school programs, summer day camp, and summer overnight camp. DPH contracted with CT Lifespan Respite Coalition, Inc. to provide 8 statewide information sessions on the Get Creative About Respite manual.

DPH is working with the Champions for Progress Center housed at the Early Intervention Research Institute at Utah State University for assistance in the production of leadership to accelerate the process of systems building at the state and community levels. The Champions for Progress Center assists with the development of private/public partnerships using a Participatory Action Research Approach (PAR), coordinates State/territory plans and activities with partners around the 6 core measures for CYSHCN.

The Newborn Screening program staff work with the 30 CT birthing facilities, State Laboratory, Audiology Diagnostic Centers, the Regional Treatment Centers and individual medical homes to assure the testing, tracking, and treatment components of the Universal Newborn Screening Hearing and Laboratory Programs.

A member of the Newborn Screening program is an active member of the CT Newborn Hearing Screening Task Force. The Task Force members include representatives from the DSS, DMR, birth hospital nurse managers, UConn Division of Family Studies, neonatologists and audiologists. The group meets monthly to plan and coordinate activities across state and other agencies, that promotes optimal outcomes for infants identified with hearing loss.

Quarterly meetings are held with a Genetic Advisory Committee (GAC), comprised of the Sickle Cell, Genetics and Metabolic specialty treatment centers and Newborn Screening Program staff from the FHS and DPH State Laboratory, as well as a consumer representative from the Citizens for Quality Sickle Cell Care, Inc.

A DPH CT Genetics Stakeholder Advisory Committee was formed to advise the Commissioner on the development of a Genomics Statewide Plan. This committee is comprised of representatives with expertise in genetics, law and bioethics; individuals from industry, insurance and academia; medical providers and genetic counselors; and consumer advocates.

Health professionals of the DPH Newborn Screening Program and the Regional Treatment Centers participate on various state, regional, and national committees and resource groups such as: the CT PKU Planning Group, NE Mothers Resource Group, New England Consortium of Metabolic Programs, NERGG, Inc., National Newborn Screening Genetic Resource Center, and the National Newborn Screening Advisory Committee. Participation on these committees provides the opportunity to network experts and consumers, participate in educational conferences, and keep abreast of advances in genetics and newborn screening as they impact public health. Program staff participate in the UConn MPH Program and provide NBS educational sessions to students as part of the Genetics course curriculum.

Site Coordinators of SBHCs meet bi-monthly with FHS staff to address grantee issues, training and technical assistance, information and resource sharing and input on overall project direction. CT SBHCs have formed a non-profit independent organization, the CT Association of SBHCs, Inc., to advocate for this service delivery model.

Sixty-three SBHCs in 18 communities are partially funded by DPH serving students in elementary, middle and high schools. SBHCs are licensed as outpatient facilities and staffed by both Advanced Nurse Practitioners and Licensed Social Workers. They offer an array of services addressing the medical, mental and oral health needs of youth, including crisis intervention, health education, social services, outreach, and substance abuse prevention services. Students enrolled in the SBHCs are provided with early periodic screening, diagnosis and treatment (EPSDT). The practitioners coordinate the care they provide with a child's primary and specialist caregivers, while integrating the needs of the child with other school personnel.

Child, Adolescent and School Health Unit staff are engaged in the interagency steering team of the Coordinated School Health Program. This team is comprised of members from DPH, SDE, and DCF. A Nurse Consultant with DPH's SBHC program is an active member of the State Adolescent Health Coordinator's Network, which is a national association of all state and territorial adolescent health coordinators, and a member of the National Assembly on School Based Health Care. Staff also participate in the Regional Stakeholders Group, with representation from DPH and SDE. The group works to enhance collaboration on issues of HIV, STDs, and Abstinence.

Within the Women, Men, Aging and Community Health Unit of the FHS, MCH program staff represent DPH on the New Haven Family Alliance, Male Involvement Network, The Community Foundation for Greater New Haven Perinatal Partnership Committee, and DSS's Fatherhood Initiative Council.

In an effort to build and strengthen community collaborations and to provide technical assistance to our community partners, DPH, in collaboration with the United Way of CT/Infoline 211, developed "A Resource Manual Designed to Help CT Communities Develop and Sustain Coalitions." It will complement the MCH Training, "Developing and Sustaining Coalitions" that was conducted in 2004 by The Consultation Center in New Haven.

Community Health Centers (CHCs) provide comprehensive primary and preventive health care and other essential public health services at 39 sites, and many additional sites for health care for the homeless. All centers are located in HPSA and/or Medically Underserved Areas and operate in accordance with Federally Qualified Health Center Guidelines. Approximately 176,894 people were served with 782,000 visits documented in 2004. Patients served within the CHCs are provided with a wide variety of comprehensive services, including EPSDT. The CHCs also work with Family Planning, WIC, SBHCs, Infoline and many community based organizations which provide other health care and social services.

The statewide family planning program is implemented through a contract with Planned Parenthood of CT in 15 sites (10 Planned Parenthood centers and 5 designated agencies). The services provided include comprehensive preventive and primary reproductive health care for adolescents and adult males and females. During FY 2004, 41,838 clients received services. The program goals and activities include education in a variety of forums for youth, parents, teachers, social workers and clergy. Forums are held in schools, churches, community based social service offices and recreational programs. The prevention focus includes the prevention of pregnancy (including abstinence education), STIs, Hepatitis and HIV/AIDS.

All DPH-funded community health centers in CT are members of the CT Primary Care Association (CPCA). DPH and CPCA work together on a number of important initiatives to promote, inform policy, and develop community based systems of care for the state's most vulnerable populations and to support CHCs. Among these are the CT River Valley Farmworker Health Program (in conjunction with the Massachusetts League of CHCs), National Health Service Corps recruitment and retention activities, immunization program initiatives, breast and cervical cancer screening, domestic violence

prevention, and homelessness.

In collaboration with CPCA, a Healthcare for the Homeless Advisory Board was established and a conference was held to strengthen links between healthcare providers and shelters. A needs assessment of homeless persons in CT and a strategic plan to improve the health status of CT's homeless men, women and children was conducted. The Advisory Board is in the process of implementing activities identified in the strategic plan. Mini-grants were provided to 10 CHCs to better address and link homeless persons in their communities with primary health care services.

DPH partnered with AHEC to co-fund and implement the CT Youth Health Service Corp (CYHSC) with a purpose of promoting teen pregnancy prevention by engaging youth in activities that promote healthy behaviors and lifestyles and support workforce development by facilitating the transition of youth from school to employment in the health care field, particularly with underserved populations. A curriculum was developed that provided students with information on confidentiality/HIPPA, Homelessness 101, Ethical and Legal Issues and Applied Health Services.

The DPH participates on the CT Breastfeeding Coalition (CBC), which includes representatives from the state and local WIC program, La Leche League, AAP, Hospitals, CHCs, HMOs, Universities, independent Lactation Consultants, Medela Corporation and consumers. The Coalition meets on a monthly basis and has 4 active committees: Policy and Advocacy, Data, Provider Education, and Public Awareness. The goals of CBC are to increase public awareness and support for breastfeeding statewide and promote breastfeeding as the social norm. In May 2005, in collaboration with the DPH, the CBC sponsored a symposium attended by over 100 health care providers, which focused on the integration of breastfeeding support in office practices. The FHS continues to work closely with the WIC program to promote and support breastfeeding in the state.

As part of the Women's Health Initiative, DPH staff actively participates in the Office of Women's Health Region One Workgroup. This workgroup is a means to increase the focus on women's health, foster collaboration, and encourage the development of women's health activities in the state and in the New England region. The DPH convened a collaborative workgroup, "Going Home Healthy," at York Correctional Institute, the State's only female correctional facility, with the purpose of transitioning women back into the community healthy. The workgroup is comprised of representatives from various state and community-based agencies. The workgroup has developed a community-specific resource guide and gender-specific discharge cards for soon to-be released inmates. In addition, DPH funded contractors have been invited to participate in the on-site "community days" so that inmates have a better understanding of where and how to access health and social services in their particular community of discharge.

During National Women's Health week, DPH collaborated with the CT Sexual Assault Crisis Services (Connsacs) and other DPH initiatives to raise awareness about sexual assault prevention, nutrition, cardiovascular disease and HIV/AIDS. Community based forums that addressed these topics were conducted in New Haven, Bridgeport, Hartford and at a shopping mall.

Facilitated by Central AHEC, DPH convened the statewide perinatal advisory committee. The purpose of this committee was to develop a comprehensive, statewide plan to address perinatal heath services in CT. Representation on the committee included: the State Agencies DPH, DSS, DCF, DMHAS, and also the New Haven Health Department, New Haven Healthy Start, The CT Hospital Association, CT Women's Consortium, CT Chapter of the March of Dimes, Real Dads Forever, Planned Parenthood of CT, CPCA, Permanent Status on the Commission of Women, AAP, UConn Department of Neonatal and Perinatal Medicine, UConn Department of Obstetrics and Gynecology, and the CT State Medical Society. The Advisory Committee identified 9 goals and objectives to address the perinatal health needs in CT.

CT's Healthy Mothers/Healthy Babies Coalition is jointly chaired by a staff member within the FHS and the CT Chapter of the March of Dimes. The mission of the Coalition is to promote the health and well being of women and children in CT through leadership, collaboration, and resource sharing.

Within the Surveillance, Evaluation, and Quality Assurance Unit (SEQA) of FHS, staff has worked to establish the CT Birth Defects Registry and work closely with birthing units within the hospitals of the state. A web-based reporting system for the CYSHCN is used by medical homes and Regional Medical Home Support Centers (RMHSC), and is linked to the registry at DPH. Infoline is working with DPH and has become the single entry-point of CSHCN for referrals to the Birth to 3 Program and the RMHSC for needed services.

SEQA staff represent DPH on the steering committee for Early Childhood Data CONNections, a public-private partnership of DSS and CHDI to bring together stakeholders to address the needs for better information on key early childhood indicators. The goal is to further build the capacity of state government to collect, analyze and report key information on the needs and services for young children (birth to age 8) and to develop and facilitate a research agenda for advancing early childhood public policy through partnerships.

The MOU between DPH and DSS regarding data exchange exists to improve public health service delivery outcomes for low-income populations through the sharing of available Medicaid, HUSKY Part B and Plus, and Title V data. The initial MOU addresses the linkage of birth and Medicaid data, childhood lead screening and Medicaid data, and data on Children Receiving Title V Services and Medicaid data.

SEQA staff act as the state identified data contact for the Office of Women's Health Region One database project. Staff has facilitated the collection of the health status information needed for this database and coordinated the subsequent in-state training for use of this database.

DPH has worked with the Office of the Governor through the Governor's Collaboration for Young Children to establish The Healthy Child Care CT initiative. This project is supported by the MCHB. Its goal is to achieve optimal health and development for all children in childcare, by guiding and supporting service integration between the childcare community and health care providers. DPH participates on the 5-member Leadership Team that guides the Healthy Child Care CT, along with the executive director of the Children's Health Council. The team has established a regional Core Committee consisting of over 55 people representing organizations that play a key role in the planning and delivery of childcare and health care for children and their families. Healthy Child Care CT also works very closely with the national Healthy Child Care America campaign, which is coordinated by the AAP with support from the DHHS Child Care and MCH Bureaus. As part of the Healthy Child Care CT initiative, DPH collaborated with staff from DSS, Yale University School of Nursing, UConn Stamford, and Southern CT State University to conduct a 6-day training program for Day Care Health Consultants, Education Consultants and Directors of Day Care Facilities. This program addressed many aspects relating to the health and safety of children in day care facilities.

The CT Coalition to Stop Underage Drinking, designed to curb under age drinking, involves all state agencies and advocacy groups across the state. The coalition is headed by the Governor's Partnership Project, Drugs Don't Work! and is funded by the RWJ Foundation.

Connecticut does not function on a county-based system for the delivery of public health services to its residents. However, the Commissioner of DPH, through the Local Health Administration Branch, assists and advises local health departments/districts in the state as they play a critical role in planning, providing, and advocating for public health services on the local level. The services provided include prenatal and family planning clinics, child health clinics, nutrition services, immunizations, communicable disease surveillance and control, HIV counseling and testing and other services. DPH's Local Health Branch administers state funding for local health departments and districts.

The Early Childhood Partners Initiative established a steering team and developed a memorandum of agreement with the Commission on Children to co-sponsor a roundtable on shared outcomes. The ECP process brought together 8 State agencies and statewide institutions, and the community to create a performance-based, outcome-driven Strategic Plan to support all CT families so their

children arrive at school healthy and ready to learn. This work has been supported by the MCHB.

To address intentional and unintentional injuries, DPH staff collaborate with the CT DOT, SDE, DCF, DSS, OCA, CSSD, and other public, private, and community-based organizations. State and local SAFE KIDS Coalitions (membership includes health care, EMS, Police, Fire and community service providers) address motor vehicle injuries. Also, DPH facilitates the CT Young Worker Safety Team, a collaboration that includes the CT and US Departments of Labor and the CT SDE. The group promotes awareness and training to decrease adolescent work related injuries. DPH facilitates the Interagency Suicide Prevention Network, an interagency, interdisciplinary collaboration that has completed a statewide, comprehensive suicide plan. DPH also works with collaborators to address violence prevention, domestic violence and child maltreatment. DPH staff participates in the Northeast Injury Prevention Network, which includes State Health Injury Prevention Programs from Regions I and II, University Injury Research Centers and representatives from Federal Regional Offices. The Network collaborates on injury prevention initiatives, including data analysis and training, of relevance to both the region and the individual states.

F. HEALTH SYSTEMS CAPACITY INDICATORS

1. The rate of children hospitalized for asthma (ICD-9 Codes: 493 -- 493.9) per 10,000 children less than five years of age.

The rate of hospitalization with a primary diagnosis of asthma appears to have increased since reporting as part of the MCHBG began in 1998. The rate was 19.3 per 10,000 children in 1998 (down from 33.5 in 1997), 30.0 in 1999, and 36.2 in 2000. (The 1998 drop in rate for one year appears to be an aberration rather than a trend.) Over the period 1992 to 2000 the average annual hospitalization rate for children ages 0-4 years was 31.1 per 10,000, which is somewhat consistent with the most recently reported rate of 36.2 per 10,000 for the general population in 2000 and 39.8 for those enrolled in HUSKY during 2003. Higher rates for hospitalizations can be seen not only in the HUSKY population, but also in residents of Connecticut's larger cities, and black and Hispanic children compared with white children. In Connecticut, the average annual hospitalization rate for black children from 1992-2000 was 54.7 per 10,000, almost five times higher than the annual average for white children.

The prevalence of asthma as reported for HUSKY A participants indicates a significant ($p<0.05$) increase from 2002-3 (8.1% to 9.1%) that is true for all three major racial/ethnic groups. Hispanics showed both the largest number and prevalence of asthma among racial/ethnic groups of HUSKY children. The Hispanic asthma prevalence rate in 2003 was 11.4% compared with 7.7% in white children and 8.6% in African-Americans.

2. The percent of Medicaid enrollees whose age is less than one year who received at least one initial periodic screen.

The percent of Medicaid children less than one who received at least one initial periodic screen increased in 2004 for the fourth year in a row. The trends in percentages were as follows: 74.0% in 2001, 80.2% in 2002, 84.6% in 2003, and the most recent year, 2004, showed 85.3%. It should be noted that not only did the percentage increase over time, but the actual number of children served has also grown steadily from 10,522 screened in 1999 to 13,475 infants screened in 2004 representing a 28% increase in infants served through the Medicaid program over this time period.

3. The percent of State Children's Health Insurance Program (SCHIP) enrollees whose age is less than one year who received at lease one periodic screen.

The percents reported for SCHIP enrolled infants served over time show an erratic pattern of increases and decreases. In 2003 approximately 74.6 percent of HUSKY infants less than one

received at least one initial periodic screen representing a decrease from 80.2 percent reported in 2002. The actual number of infants screened, however, has shown a clear trend of constant improvement with a notable 300% increase from 134 infants screened in 1999 to 403 in 2003.

4. The percent of women (15 through 44) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index. Approximately 84.4 percent of women (15 through 44) with a live birth in 2003 received prenatal care scoring at least 80 percent as measured by the Kotelchuck Index. This was a slight decrease from 84.6 percent of women with a live birth in 2002. Further analysis would be required to determine whether there were significant variations within this cohort of women based on age, race, health insurance or other factors. Appropriate programmatic interventions could then be tailored to the problems identified. HSCI 05C reports that in 2003 88.8% of these women began prenatal care in the first trimester.

5. Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State.

For the 2000 birth cohort year there was a match of Medicaid records and Vital Records completed by the Children's Health Council under agreement with the Department of Social Services (DSS) and the DPH. Data are presented for that year in the columns headed "Medicaid" and "Non-Medicaid" for all but HSCI 5B,the Infant Mortality Rate, which is not available by Medicaid status. DPH has worked with DSS in establishing a Memorandum of Understanding with the goal of ensuring that this record match be available every year.

For all three indicators the Medicaid population shows poorer outcomes than the Non-Medicaid population. HSCI#05A: 9.1 percent of the deliveries paid for by Medicaid were low birth weight babies in comparison to the Non-Medicaid population's experience of 6.9 percent low birth weight. For HSCI#05C, Medicaid mothers were less likely to receive prenatal care beginning in the first trimester (79.3% Medicaid versus 91.5 % for the Non-Medicaid population). Similarly HSCI#05D reports that the Medicaid population's prenatal care Kotelchuck score was worse than the Non-Medicaid women's experience (80% Medicaid versus 88.5 % Non-Medicaid population).

The column labeled "All" contains Vital Records information for 2003 for the entire state population. Two of the four measures, HSCI 5A and B, showed improvement from 2002 to 2003 in Low Birth Weight and Infant Mortality Rates. HSCI#05C Early Entry into Prenatal Care remained the same for both 2002 and 2003. Approximately 84.4 percent of women (15 through 44) with a live birth in 2003 received prenatal care scoring at least 80 percent as measured by the Kotelchuck Index. This was a slight decrease from 84.6 percent of women with a live birth in 2002.

6. The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs for infants (0 to 1, children and pregnant women.

Infants, Children up to age 16, and Pregnant Women are eligible for Medicaid if the family income is less than 185 percent of the poverty level. Infants, Children up to age 19, and Pregnant Women are eligible for SCHIP or HUSKY if the family income is less than 300 percent of the poverty level.

7. The percent of EPSDT eligible children age 6 through 9 years who have received any dental services during the year.

The percent of EPSDT eligible children age 6 through 9 years who have received any dental services during 2004 was 46.5 %. This percentage is part of a consistent trend toward improvement and, specifically, an increase from 45.4 % in 2003. The actual numbers receiving dental services jumped from a low of 16,309 in 2000 to 25,099 in 2004, a 54% increase in children age 6 through 9 who have received any EPSDT dental services during the year. While this is a welcome increase, provision/availability of dental services remains an important need in Connecticut especially among the poor and uninsured. Connecticut's OPENWIDE program has made progress in increasing the

ability of non-dental health professionals to make appropriate referrals for dental care.

8. The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs Program.

In 2003, 7.3 percent of SSI beneficiaries received CSHCN services, which remains unchanged from 7.3 percent in 2002.

9a. The ability of States to assure that the Maternal and Child Health program and Title V agency have access to policy and program relevant information and data.

Some improvements, as well as areas of continued challenges, have been seen in this indicator over past years. There was a link of Medicaid and birth records for the year 2000 birth cohort. A new MOU between the Department of Social Services (DSS) and DPH will facilitate making this vital records linkage an ongoing project. Also, the CSHCN Registry became operational in the fall of 2002.

9b. The ability of States to determine the percent of adolescents in grades 9 through 12 who report using tobacco products in the past month.

Connecticut uses data from the Youth Risk Behavior Survey (YRBS) as a source of youth tobacco use information. Data from the YRBS conducted in 2003 indicates that 22.5 percent of high school students surveyed have smoked a cigarette within the past 30 days. In 2005 the DPH has partnered with SDE in the administration of a joint YRBS/Youth Tobacco Survey (YTS) to a sample of CT school children under the new name of CT School Health Survey.

9c. The ability of States to determine the percent of children who are obese or overweight.

Connecticut has access to data from the Youth Risk Behavior Survey (YRBS) for height and weight information in youth. In 2003, data from the YRBS indicated that 11.6 percent of high school students surveyed were obese or overweight. Connecticut, through its WIC program, participates in the Pediatric Nutrition Surveillance System (PedNSS). Also, local WIC Programs in Connecticut enter weight and height data on children up to 5 years of age into the Statewide WIC Information System "SWIS." The data are provided to the local WIC office via the child's primary health care provider at six month intervals for the purpose of WIC eligibility determination. The data are stored and tabulated at the state level.

IV. PRIORITIES, PERFORMANCE AND PROGRAM ACTIVITIES

A. BACKGROUND AND OVERVIEW

The priority needs presented in the next section were identified through a comprehensive needs assessment during August 2004 through May 2005, to identify state MCH priorities, to arrange programmatic and policy activity around these priorities, and to develop state performance measures to monitor the success of their efforts. The MCH needs assessment was designed to be population-based, community-focused, and framed within a family context.

The MCH Director established an MCH Needs Assessment Planning Committee to assist in the oversight and direction of the needs assessment. The Planning Committee included staff from the various MCH programs, staff from the Health Information Systems and Reporting Section, and staff from the Health Education, Management, and Surveillance Section.

In order to include key stakeholders in a meaningful and integral part of the needs assessment, DPH staff identified and convened an initial collaborative meeting with many invited state agencies and community and professional organizations. The MCH Director presented an overview of the MCH Block Grant and the required five-year needs assessment at the initial collaborative meeting. This collaborative group, which met several times over a six-month period, also provided oversight of the community centered needs assessment.

The Planning Committee also determined that the needs assessment process would include two components: 1) DPH Internal Needs Assessment, and 2) Community Centered Needs Assessment. The DPH Internal Needs Assessment process gathered data and reports housed at DPH, interpreted the data for programmatic implications, and recommended 7-10 state priority needs. The Community Centered Needs Assessment process identified community level data and reports, and all methods of collecting community data. This provided a forum for community input into the determination of the state priority needs.

Each Internal Needs Assessment workgroup was instructed to recommend 5 priority needs for a total of 15 priority needs to be considered by the DPH Planning Committee. It was part of the Planning Committee's charge to reduce the recommended 15 priority needs to 7-10 state priority needs. The Planning Committee, after much discussion and consideration, drafted a set of state priority needs, which were subsequently considered along with those identified by the Community Centered Needs Assessment.

In the Community Centered Needs Assessment, both qualitative and quantitative methods were used to inform the comprehensive needs assessment process. A health profile was developed for target populations including women, pregnant women, children, adolescents and children with special health care needs (CYSHCN). Additional feedback on the health needs of women and children was obtained from providers and consumers. Engaging the various stakeholder groups facilitated the inclusion of their insights and experience of their practical experiences and served as a valuable reality check. A concerted effort was made to engage providers, advocates and consumers in both identifying priority needs and successful solutions to identified problems.

The Planning Committee met in late May 2005, to review the identified priority needs from the Internal and Community Centered Needs assessment components to assure that the three population groups were appropriately included and establish measurable State Performance Measures. The MCH program selected seven priority needs from the list of potential areas for improving maternal and child health. Criteria used to select top priorities include the likelihood that the intervention will result in improved maternal and child health outcomes, the feasibility of success, and alignment with federal MCH priorities. The DPH Planning Committee added an eighth priority need regarding health disparities as it was deemed a repeated imperative need across the MCH population. The DPH Planning Committee also added a ninth priority need as part of the collaborative work of the federal Region I states to "measure the collective assets of their childhood health systems."

The nine identified State Priority Needs are similar in many ways to those identified 5 years ago. The similarities include the need to address data capacity issues, reduce injuries to children and adolescents, improve child adolescent health status with an added focus on overweight/obesity, enhance CYSHCN services especially family support services, increase access to health care for women and children, and reduce the health disparities that continue to exist specifically in the areas of teen pregnancy, low birth weight, prenatal care, breastfeeding, and infant mortality. One change was the removal of the priority need related to asthma diagnosis and management, as DPH has enhanced its capacity to more effectively address this issue through the now well-established DPH Asthma Program. Another change was the inclusion of the need to address asset-based measurement efforts among the federal Region I states.

B. STATE PRIORITIES

Through the Needs Assessment process completed for the 2006 Application, DPH identified nine areas of priority needs. These nine areas and how they relate to the National and State Performance Measures, and the capacity and resource capability of the Title V program are described below.

1. Strengthen Data Collection and Reporting

Effective decision-making requires timely and useful data on maternal and child health. One strategy that DPH implemented was the creation of the Virtual Children's Health Bureau (VCHB) in the fall 2004, whose charge was to remove barriers to the effective and efficient sharing of data across sections of the agency to fully maximize the use of child health information. The resulting commitment from DPH staff and executive leadership was the creation of a data warehouse of high-quality linked child health data, which has been titled HIP-Kids (Health Informatics Profile for CT Kids).

The information from HIP-Kids will be an important data source to enhance the DPH's ability to report on performance measures, as well as other required outcome measures. It also will support the goal outlined in the Health Systems Capacity Indicator #9A "the ability of states to assure that the MCH Program and Title V agency have access to policy and program information and data."

This priority need is somewhat related to HP2010 23-11: (Developmental) Increase the proportion of State and local public health agencies that meet national performance standards for essential public health services.

The SPM #1, to create HIP-Kids, will support interdivisional public health research activities and initiatives. A broadly accessible data system will enhance the capacity to conduct public health assurance and assessment activities within Connecticut, and will also inform public health policy. Some enhanced essential activities that are anticipated include reducing health disparities among childhood disease prevention activities through better outreach to "hard to reach" populations; increasing ability to evaluate population-based health activities within DPH; improving data quality through better data validation and coordinated data improvement efforts; and enhancing comprehensive data accessibility to support grant activities and health programming.

2. Establish Collaborative Relations at the State/Local Level

The MCH Program acknowledges that improving the health and well-being of women and children requires a collaborative response from state agencies and community providers. For this reason, the MCH Program proposes to enhance and establish formal processes to collaborate with state and local stakeholders committed to improving the health of women and children. Specific issues best addressed through collaborations with state and local partners include increasing access to needed services such as mental health, oral health, specialty care and health services in rural communities, and expanding access to health insurance for low income populations.

While there are no specific National Performance Measures (NPMs) that directly relate to this priority need, the NPMs seek to improve the health of women and children, and many NPMs can only be

achieved by collaborating with other state agencies. Similarly, there are no HP2010 objectives that specifically discuss fostering and implementing collaborations with state and local stake holders, however there are numerous HP2010 objectives relating to the overarching goal to improve the health of women and children (refer to Form 16).

3. Reduce Intentional Injuries

The increase in violence and intentional injuries poses a serious public health threat to the adolescent population. Participation in fights is one marker of violent behavior that often results in serious injuries. Efforts to decrease violent behavior will help reduce intentional injuries to adolescents.

The single NPM most closely related to this priority need is #16, the rate of suicide deaths among youths. The selection of this priority need and the related SPM to reduce the number of injuries to adolescents in grades 9-12 due to violence and intentional injury, was purposely identified as part of an early intervention and prevention concept with the intent to address the tendencies to violent and injurious behaviors at an earlier stage. There are three HP2010 objectives that were cited related to this priority need from the Injury and Violence Prevention Chapter of the HP2010 document (see Form 16).

There are several Title V programs (e.g., CHCs and SBHCs) that already address this priority need through education and prevention programs, as well as specific programs like anti-bullying campaigns.

4. Improve Adolescent Health Status

Adolescents of diverse racial, ethnic backgrounds and those of low socio-economic status who live in very rural sections of the state are at especially high risk for mental health, substance abuse and unintentional injuries. They need easy access to age-appropriate services and are often under-served due to the gap between pediatric and adult medical care services. SBHCs are reaching a number of adolescents but are only available at some schools and not in others. In addition, there is a sub-population of adolescents who are not reached because they are not in school due to dropping out, being incarcerated or are migrant workers.

While there is no specific NPM to address the increase in access to age-appropriate services for adolescents 10-20 years, HP2010 1-4b addresses this priority need with the goal to increase the proportion of persons who have a specific source of ongoing care (Children and youth aged 17 years and under). The HP2010 objective states that, "Young children and elderly adults, aged 65 years and older, are most likely to have a usual source of care, and adults aged 18 to 64 years are least likely. Young adults aged 18 to 24 years are the least likely of any age group to have a usual source of care."

The availability of age-appropriate services for adolescents through the SBHCs has been a positive model in which there has been moderate increased capacity to serve adolescents. The new SPM #4 related to this priority need will seek to further increase this capacity.

5. Promote Nutrition and Exercise to Reduce Obesity

Obesity and its consequences is now the top emerging public health issue in the state. Its importance as a priority health issue stems from it being a preventable condition that is increasing across all major public health population groups, and that it is linked to health problems such as heart disease and Type II diabetes. Obesity is an ideal health issue for community wide action that addresses all aspects of its prevalence among the MCH population.

While there is no NPM that addresses obesity/overweight directly, the new Health System Capacity Indicator #9C seeks to measure whether States have the ability to determine the percent of children who are obese or overweight. CT should be able to obtain percentages from the 2007 and 2009 CT

School Health Survey (with a YRBS component) to determine this percentage. As a complimentary approach, the SPM developed for this priority need was focused on the reduction of overweight/obesity in the child and adolescent population with the increase in the number of public schools using educational programs to reduce obesity through physical exercise and nutrition education.

There are several HP2010 objectives that were cited related to this priority need (see Form 16). The capacity for the State to address this priority need will be possible through a formal collaboration with the Department of Education (see new SPM #2) to promote culturally appropriate physical activity and nutrition in schools. This would be especially possible through the Coordinated School Health Model.

6. Increase Access to Pre-conception Education and Parenting

Overall Connecticut's families and children fare well compared to their national counterparts with respect to key national indicators of maternal and child health. Birth rates in Connecticut are lower than national rates; there are proportionally fewer pre-term births; and there are smaller percentages of low birth weight babies. Connecticut children overall are also more likely to receive primary care services, including dental care and other routine and preventive services.

However, there are great disparities in many of the key health indicators between certain segments of the state's population, particularly between teens and adult populations and White (non-Hispanic) majority and minority populations. The causes of some of these disparities are linked to poverty, racism, and other societal problems but many of the disparities are also clearly linked to lack of proper pre-conception education, parent education, and other parenting supports. Young and inexperienced parents, as well as parents with limited knowledge of healthy behaviors and habits, need to have better access to formal, quality pre-conception and parenting education programs.

This priority need directly relates to NPM 18, with a focus on the women under age 20 years, since it was identified that the teen population was a disparate group needing particular attention, as well as race and ethnic disparities. There were three HP2010 objectives identified from the Maternal, Infant and Child Health chapter (see Form 16).

CT could address this priority need by: identifying and promoting the development of quality pre-conception and parent education programs, particularly in the schools and in areas where there are high rates of teen births; developing and disseminating culturally appropriate educational materials and curricula geared to teens and young adults; tracking the number of teens and young adults who receive quality pre-conception and parent education in schools and in other community settings; and promoting provider training and education programs geared to encouraging brief pre-conception counseling and parenting education and referral to community-based educational programs.

7. Promote access to family support services including respite care and medical home system of care for Children and Youth with Special Health Care Needs

According to data collected by the SLAITS survey there could be as many as 118,000 children with special health care needs living in CT. A number of agencies in the State assist CYSHCN and their families by providing and facilitating family support services including respite care. The two major agencies are DPH and the Department of Mental Retardation (DMR). Great strides have been made to identify and serve families with CYSHCN in the state, particularly families with young children but there are still many families who struggle and efforts need to be made to: 1) improve access to family support and respite care, 2) increase the overall service capacity and the resources available for home and respite care, and 3) support families who have trouble identifying respite providers.

This priority need has three NPMs that relate to the need to increase access to family support services including respite care and the medical home system of care for CYSHCN (NPM #2, #3 and #5). This SPM was developed with the particular focus on assuring that families have access to

respite services and the new medical home system of care. There were 3 HP2010 objectives identified related to this priority need (see Form 16) including that have a focus on medical home and service systems for CSHCN.

To address this priority need, the State will use the newly initiated community-based system of care for children and youth with special health care needs. This initiative complements the American Academy of Pediatrics belief that all children should have a medical home where care is accessible, family-centered, continuous, comprehensive, coordinated, compassionate and culturally competent.

Five RMHSCs will be contracted as of July of 2005. Through linkages, the outcome is for the RMHSC to increase the number of children screened and identified with special health care needs in the region by coordinating family support services and respite care, educating health and social service providers on the resources available to families of CYSHCN, collaborating with community-based organizations, colleges and universities in the state, particularly those with training programs for students who want to provide services to CYSHCN; and promoting the development of respite care practicum programs that link students to families who need respite care services.

8. Reduce health disparities especially related to Access to care, Race/ethnicity, and Geographic location. (Specific issues: teen pregnancy, low birthweight, prenatal care, breastfeeding, and infant mortality)

Compared to national statistics, CT residents report good health status overall, however, large health disparities exist between the White population and that of the African American/Black and Hispanic populations within CT. This issue was identified in the last needs assessment conducted four years ago, and remains one that DPH needs to focus efforts. Specifically, lack of access to health care for low income and uninsured populations differs across these populations. Even women with health insurance lack access to mental health, oral health and specialty care services including follow-up procedures and testing due, in part, to high out-of-pocket expenses.

Lack of access to basic needs negatively impacts overall health status of target populations. There are documented delays in seeking care by hidden populations including undocumented, immigrants and refugees. In general, these populations are not seeking routine and preventive care due to both perceived and actual barriers, which contributes to poor health outcomes and a greater burden on the health care delivery system. Significant health disparities are documented with African American/Black and Hispanic populations experiencing dramatically poorer health status. While the overall percent of births to teens has dropped in the last decade, especially among African Americans/Blacks, there remain a greater percentage of pregnancies among these teens when compared to white teens.

While there was no specific SPM developed for this priority need, the goal to reduce health disparities has been incorporated explicitly in two of the SPMs, e.g. the reduction of intentional injuries and infants whose mother received prenatal care in the first trimester. All of CT's MCH programs collect standardized racial and ethnic information of populations they serve with the overarching goal to monitor whether or not these programs are meeting the needs of all sub-populations.

9. Collaborate with the other federal Region I states to develop indicators that measure the collective assets of their early childhood health systems, "specifically focusing on their collective assets regarding child care health consultants (CCHC)."

SPM to be determined.

C. NATIONAL PERFORMANCE MEASURES

Performance Measure 01: *The percent of newborns who are screened and confirmed with condition(s) mandated by their State-sponsored newborn screening programs (e.g. phenylketonuria and hemoglobinopathies) who receive appropriate follow up as defined by their State.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective				100	100
Annual Indicator			100.0	100.0	100.0
Numerator			43	41	43
Denominator			43	41	43
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	100	100	100	100	100

Notes - 2002

Source: CY2002 CDPH Newborn screening program for percent confirmed cases who also received appropriate followup. (See also Form 6) Last matching of all births with screenings showed 99.98% of newborns screened.

Notes - 2003

Source: CY2003 CDPH Newborn screening program supplied the percentage of confirmed cases who also received appropriate followup. (For more info. on CT's newborn screening procedures/data see also the detailed note with Form 6.)

Notes - 2004

Source: CY2004 CDPH Newborn Screening program supplied the percentage of confirmed cases who also received appropriate followup. (For more info. on CT's newborn screening procedures/data see also the detailed note with Form 6.)

a. Last Year's Accomplishments

CT met its objective by assuring that 99% of all infants born in the state received newborn screening prior to discharge or within the first week of life. In 2004, of the 42,705 initial screens, 1,347 suspect positive results were reported. Of these, 52 were confirmed. The number identified with Hemoglobin Traits was 809. Positive screens were referred to Regional Treatment Centers for confirmation testing, treatment, education, counseling, and follow-up services. Of the 32 cases of unsatisfactory newborn screening specimens, all were followed up for a 2nd specimen. There were 8 CT State Waivers submitted to the lab for refusal to receive screening due to conflicts with religious tenets, 2 of which received screening through their PCP.

Please see the Attachment to this section for the full listing of CT's NBS panel. Prior to the May 1, 2004 expansion of NBS, courier services were established to have specimens picked up from the birthing facilities and delivered to State Lab. Routine 2nd specimens were eliminated with the implementation MS/MS testing and expansion and the fees increased to $28.00 to the birthing facilities.

There were 30 birthing facilities utilizing the Newborn Screening System (NSS) of electronic reporting of demographic and laboratory testing information. The NSS links demographic data

for the mother, newborn and primary care provider to the newborn laboratory and hearing screening programs and the birth defects registry.

The Child Health Profile, a data repository for newborn lab, hearing and birth defect registry data was linked to the Newborn Tracking System Database (NBTS). The NBTS that maintains the data for all positive screens was enhanced to include all the expanded disorders, form letters to PCP's for suspect positives, referrals to Regional Treatment Centers, final laboratory reports, and letters to PCP's and parents.

Staff met monthly to discuss emerging genetic issues. Program staff met quarterly with the Genetics Advisory Committee (GAC) to discuss issues related to newborn screening, including expansion, and proposed newborn screening legislative bills.

Technical assistance was provided by DPH staff to the birthing facility health professionals, primary care providers, families, and the general public. The Genetic Newborn Screening website was updated with information to health care providers and families, including Fact Sheets for each disorder screened in CT, general information, and links to other websites.

CT partnered with the other New England states and submitted grant activities for a Genetic Education Project as part of a collaborative Grant submitted through NERGG, Inc. The Genetic Regional Treatment Center Genetic Specialists provided genetic newborn screening educational programs through grand rounds conferences throughout the state.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Workplans developed and implemented to address the expansion of NBS to more than 30 diseases.				X
2. Participate in the quarterly Genetics Advisory Committee (GAC) meetings.				X
3. Work with other groups to provide education on Genetics and NBS.				X
4. Screen all infants for selected metabolic or genetic diseases.			X	X
5. Refer newborns with abnormal screening results for appropriate services.			X	
6. Update educational programs to reflect the expansion of the NBS testing panel.			X	X
7. Enhance the electronic reporting Newborn Screening System (NSS) for transfers of Newborns to NICUs.				X
8. Workgroup continues to meet to address the need for linkage of the NSS data with other databases.				X
9. NBS staff continues to participate in various State, Regional, and National conferences.				X
10. NBS staff continue to support families identified with genetic and metabolic diseases.		X		

b. Current Activities

DPH continues to assure early identification of infants at increased risk for selected metabolic or genetic diseases. In collaboration with the Genetics Advisory Committee (GAC) specialists, DPH continues to revise guidelines, protocols, brochures, and fact sheets to reflect the

expansion of the NBS testing panel.

CT is partnering and participating in the HRSA Grant awarded to the New England Regional Genetics Group, Inc., (NERGG) New England Genetic NBS Collaborative Projects. CT DPH continues to collaborate with the NERGG and other grant application opportunities to obtain financial resources to address our genetic and NBS, and transition to adult care needs.

The DPH NBS staff continues to meet quarterly with the GAC to discuss issues relevant to newborn screening and genetics. The State designated Genetic Regional Treatment Center Genetic Specialists continue to provide genetic newborn screening educational programs through grand rounds conferences throughout the state.

The quality improvement reviews are ongoing to assure that all newborns are screened in a timely and accurate manner to enable prompt identification of disorders and referrals to State designated Regional Treatment Centers for confirmation testing, treatment, education, counseling, and follow up services. The laboratory designated a staff person to develop and perform quality assurance activities assuring timely and accurate testing from receipt of the specimen to the completion of testing and reporting of results as well as other laboratory requirements. NBTS staff meets with the laboratory staff monthly to discuss quality assurance (QA) issues and to get updates on the plans for expanded screening. Other reviews include but are not limited to: unsatisfactory specimens, CT Waivers for objection to testing, transfusions, timeliness receipt of NBS specimens and others.

Statistical program reports are produced on a monthly and yearly basis and are used to respond to various state, regional, and national requests and required reports.

Physician's and Birthing Facility Guidelines for Laboratory NBS continue to be revised for distribution and posting to the DPH NBS website. Other educational Genetic and NBS information continues to be included on the website.

NBS staff participated and collaborated with the DPH Genetic Planning Team in the implementation of the HRSA Genetic Planning Grant activities leading to the development of the CT Genomic Action Plan. This included participation at various Gene Team and Stakeholders meetings and submission, reviewing and providing input on the various sections of the Genomic Action Plan. A Genetic NBS nurse consultant has been appointed to be part of the newly established DPH Virtual Office of Genomics.

c. Plan for the Coming Year

CT will continue to assure that infants are screened for early identification of those at increased risk by adding other selected metabolic or genetic diseases to the screening panel. All newborns with abnormal screening results will continue to be referred to State, Regional Treatment Centers for comprehensive testing, counseling, education, and treatment services so that medical treatment can be promptly initiated

Quality improvement reviews will continue to assure that all newborns are screened in a timely and accurate manner to enable prompt identification of disorders and referrals to State designated Regional Treatment Centers for confirmation testing, treatment, education, counseling, and follow up services.

The NBTS database will continue to be modified to accommodate further expansion of potential additional disorders and to improve report output capability. A linkage will be developed between the NBS and the electronic vital records system database to assure that each child born receives a laboratory screen.

NBS will continue to work collaboratively with the GAC, the specialty treatment centers, and others in the development and implementation of educational materials and programs. DPH will continue to enhance the website with additional information.

NBS staff will continue to participate and collaborate on the implementation of the CT Genomic Action Plan and activities of the plan.

Performance Measure 02: *The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective				59.8	59.8
Annual Indicator			59.8	59.8	59.8
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	59.8	59.8	59.8	59.8	59.8

Notes - 2002

Source: SLAITS, 2002

Notes - 2003

The data reported in 2002 have pre-populated the data for 2003 for this performance measure. CT has no updates to the national SLAITS Survey data, as reported previously, for national performance measures #2-6.

Notes - 2004

The data reported in 2004 are pre-populated with the data from 2004 for this performance measure. CT has no updates to the national SLAITS Survey data, as reported previously, for national performance measures #2-6.

a. Last Year's Accomplishments

According to data from the State and Local Area Integrated Telephone Survey (SLAITS) conducted from October 2000 to April 2002, 59.8% of families of CSHCN in CT partner in decision-making and are satisfied with the services received, compared to 57.5% nationally. CT met this objective.

The two CSHCN Centers located at the CT Children's Medical Center in Hartford and Yale University in New Haven, ensured family involvement in decision-making regarding their

children's care coordination. Staff at the Centers, including Family Advocates (parents of CSHCN), linked families with each other and with community-based services, attended planning and placement team meetings, and provided other needed supports. The Centers employed bilingual staff for Latino support and self-advocacy groups. Family satisfaction surveys were distributed to families.

DPH designed a new community-based Regional Medical Home Support Center (RMHSC) System of Care for Children and Youth with Special Health Care Needs. Family-centered care is a fundamental component of the system. Each RMHSC will have specific responsibilities related to the establishment and growth of family and professional partnerships. The RMHSC and the Regional Family Support Network (RFSN) will work closely on developing family-to-family support activities, assisting primary care providers to involve families to improve practice standards, and implementing partnership roles.

The RFSN will assist the RMHSC and Medical Homes in the region to expand the level of support, information, referral and networking available to families. The RFSN will be available to assist families with questions, family-to-family support and family empowerment. The RFSN will be available to assist the RMHSC with family-centered training, capacity building, and more.

Families were active members of the legislated Family Support Council, CT Lifespan Respite Coalition (CLRC), New England SERVE and Family Voices. DPH compensated families to review CT's Title V Maternal and Child Health Block Grant (MCHBG). DPH also invited families to comment at the MCHBG public hearing. A DPH staff parent of CSHCN was available to all Maternal and Child Health Programs within DPH and to the CSHCN Centers.

DPH and CLRC partnered to create the "Get Creative About Respite" manual, and eight statewide information sessions to empower families to find affordable, quality respite care and encourage new informal providers of respite care. Follow-up survey results were positive. (See DPH website: http://www.dph.state.ct.us/BCH/Family%20Health/cyshcn/cyshcn-medical%20home%20site.htm)

A great deal of change was realized through the family involvement component of the Medical Home Learning Collaborative process. The introduction of family surveys and screeners resulted in family participation in care plans and the creation of a pre-visit questionnaire.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Enable families to participate in forums, meetings, and Block Grant review.				X
2. Family surveys are distributed to all families.		X		
3. Families partner in decision making.				X
4. Establish and encourage growth of family/professional partnership.				X
5. Assure that families are satisfied.		X		
6.				
7.				
8.				
9.				

10.				

b. Current Activities

The two CSHCN Centers located at the CT Children's Medical Center in Hartford and Yale University in New Haven continue to ensure families are involved in decision-making regarding their children's care coordination. Staff at the Centers, including Family Advocates (parents of CSHCN), continue to link families with each other and with community-based services, attend planning and placement team meetings, and provide other needed supports. The Centers continue to employ bilingual staff for Latino support and self-advocacy groups. Family satisfaction surveys continue to be distributed to families.

The RMHSC System of Care for CYSHCN is being implemented in July 2005. Family-centered care is a fundamental component of the system. Each RMHSC has specific responsibilities related to the establishment and growth of family and professional partnerships. The RMHSC and the Regional Family Support Network (RFSN) are working closely on developing family-to-family support activities, assisting primary care providers to involve families to improve practice standards, and implementing partnership roles. See website (http://www.dph.state.ct.us/BCH/Family%20Health/cyshcn/cyshcn-medical%20home%20site.htm) for more information.

The RFSN is assisting the RMHSC and Medical Homes in the region to expand the level of support, information, referral and networking available to families. The RFSN is available to assist families with questions, family-to-family support and family empowerment. The RFSN is available to assist the RMHSC with family-centered training, capacity building, and more.

Families continue to be active members of the legislated Family Support Council, CT Lifespan Respite Coalition (CLRC), New England SERVE and Family Voices. DPH continues to compensate families to review CT's Title V Application. DPH also continues to invite families to comment at the MCHBG public hearing. A DPH staff parent of CSHCN continues to be available to all MCH Programs within DPH and to the CSHCN Centers.

DPH is providing each RMHSC and medical home with a standardized, web-based data system (DocSite) to collect, manage and report information on children and youth with special health care needs. The system will allow DPH to collect information from families to support CYSHCN program surveillance and planning (see website listed above for more information).

DPH is partnering with Elkinson & Sloves, a media consultant, to develop a market feasibility analysis and action plan to promote partnerships between families of children and youth with special health care needs, their physicians and coordinated community resources. Interviews and assessments of target markets (families, providers and insurers) continue to be conducted to analyze market conditions, formulate messages and finalize the action plan.

c. Plan for the Coming Year

The Regional Medical Home Support Centers (RMHSC) will fulfill their responsibilities related to the establishment and growth of family and professional partnerships. Standardized family satisfaction surveys will be administered through DocSite and will continue to be distributed to families. DPH will use information collected by the surveys to help shape enhancements to the RMHSC System. The Regional Family Support Network will continue to grow and be better able to serve families of children and youth with special health care needs statewide.

Families will continue to be active members of the legislated Family Support Council, CT Lifespan Respite Coalition (CLRC), New England SERVE and Family Voices. DPH will continue to compensate families to review CT's Title V Maternal and Child Health Block Grant (MCHBG). DPH will also continue to invite families to comment at the MCHBG public hearing.

A DPH staff parent of CSHCN will continue to be available to all Maternal and Child Health Programs within DPH, the Regional Medical Home Support Centers, medical homes and Regional Family Support Network.

DPH will continue to monitor, enhance, and revise the statewide respite system as necessary. DPH will continue to distribute the "Get Creative About Respite" manual through community activities.

Performance Measure 03: *The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective				56.9	56.9
Annual Indicator			56.9	56.9	56.9
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	56.9	56.9	56.9	56.9	56.9

Notes - 2002

The 2002 indicator is based on the State estimates from SLAITS.

Notes - 2003

The data reported in 2002 from the SLAITS Survey have pre-populated the data for 2003 for this performance measure.

Notes - 2004

The data reported in 2002 from the SLAITS Survey have pre-populated the data for 2004 for this performance measure.

a. Last Year's Accomplishments

Data from the State and Local Area Integrated Telephone Survey (SLAITS) conducted between October 2000 and April 2002 indicated that in CT, 56.9% of CSHCN ages 0 to 18 receive coordinated, ongoing, comprehensive care within a medical home. This percentage is slightly higher, but statistically similar to the national estimate of 52.6%.

In FY 2004, 170 of 178 children (95.5%) enrolled in the CSHCN Program Centers were identified to have a Primary Care Provider (PCP) as a medical home. The Centers coordinated activities to supplement care received from the PCP.

The transition plan developed by the state task force of the two CYSHCN Centers, other state agencies, the Office of the Child Advocate and DPH staff for CYSHCN and their families/caregivers was implemented. Strategies included the redirection of Centers' operations to focus more on care-coordination and spread of the medical home initiative and the implementation of a community-based system of services targeting regionalized respite and care-coordination.

CT completed participation in the National Initiative for Children's Healthcare Quality's (NICHQ) Medical Home Learning Collaborative (MHLC) that began in April 2003. The CT Team included DPH staff and three pediatric primary care providers, nurse manager and parent partner. Title V staff facilitated bimonthly CT MHLC meetings to identify improvements in services for CYSHCN and their families/caregivers.

The CT MHLC led a NICHQ national teleconference, "Care Coordination and the Delivery System Design," presenting CT's response to the challenge of integrating medical homes into a community-based service delivery system for CYSHCN.

Through a contract amendment, each CYSHCN Centers identified 5 new pediatric practices committed to the medical home concept. These practices received extensive orientation and training at a June 2004 seminar introducing them to the medical home concept became active members of the CT MHLC to promote early identification of CYSHCN through use of a Screener and Complexity Index Tool.

A second contract amendment charged the CYSHCN Centers with implementing Quality Improvement Programs that included an Internal Quality Assurance Plan that described how the Centers would operate a specialty care infrastructure development system to improve access and quality to coordinated special health care for CYSHCN. Both Centers focused on services necessary to make successful transitions to all aspects of adult life for CYSHCN with cystic fibrosis, genetic disorder or birth defect, cerebral palsy and craniofacial defects. They identified the importance of a comprehensive medical transition plan and ongoing fluency of communications between the CYSHCN, their pediatric/adolescent provider and the adult primary care provider.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide early identification of CSHCN and referral to PCP/medical home and provide care coordination.		X		
2. Conduct tracking and follow-up with birth hospitals to assure that they report children with special health care needs on each new birth		X		
3. Develop a tracking system for all referrals made between the CDI, PCP and the RMHSC that assures appropriate care coordination of services		X		
4. Coordinate with the Medical Home Collaborative.				X
5. Implement the medical home support centers.		X		X
6. Integrate the Parent Network with the RMHSC				X
7. Convene State-wide advisory group to support and enhance the RMHSC				X
8.				

9.				
10.				

b. Current Activities

The two CYSHCN Centers were redirected through technical contract amendments, with specific focus on care coordination activities for all CYSHCN and a strategy to improve primary care providers' capacity to apply the CSHCN Screener and CYSHCN Complexity Index Tool.

The legislated Medicaid Managed Care Council, convened a working group of agency representatives, managed care organizations (MCO), pediatricians, and children's advocates to discuss the development of care coordination and medical home services for children and youth with special health care needs who are served by CT's Medicaid Managed Care plans (HUSKY). The work group concluded that Medical Home services could provide real benefit to CYSHCN, with an added benefit to having those services provided at the primary care level. DSS was directed to develop a uniform definition of CSHCN for all MCOs to use, uniform standards of eligibility and services for MCO case management services and PCP billing and reimbursement standards for MH care coordination services.

Through a Request for Proposal (RFP), five health-based organizations were selected and will serve as regional centers to enable CYSHCN and their families to access quality health care services in their local communities. The goals of this community-based system of care will: 1) reach more CYSHCN and the families and assist them with coordination of multi-system of care they need to access; 2) provide training and support to the PCPs to improve quality of care by addressing family needs that will optimize the health of their CYSHCN; 3) assist the PCPs with care coordination of CYSHCN who have high severity of needs; 4) assist with the coordination between the PCPs and specialists; and 5) promote the establishment of ?Medical Home' with PCPs that serve the pediatric population and care for CYSHCN.

DPH, through its partnership with the Child Health & Development Institute, contracted with the University of CT Area Health Education Centers (AHEC) to develop and implement a Medical Home Academy (MHA) for pediatric health care providers and families (please see website http://www.dph.state.ct.us/BCH/Family%20Health/cyshcn/cyshcn-medical%20home%20site.htm for more information). The curriculum of the MHA will help ensure that providers are knowledgeable and skilled at providing CYSHCN in the State and their families/caregiver with coordinated, ongoing, comprehensive, community-based care within a medical home.

DPH will partner with the AJ Pappanikou Center at the University of CT Health Center to coordinate three meetings this year with key representatives of the state agencies and other stakeholders in CT servicing children with special health care needs. The purpose of these meetings is to deduce a common definition, standard elements and outcomes measures for "care coordination". The outcome from this meeting will be adapted to train the care coordinators employed by the RMHSCs.

c. Plan for the Coming Year

Based on the report defining care coordination, there will be biannual facilitated meetings of inter-agency care coordinators and other key community stakeholders of direct services, including advocates for CYSHCN at the regional level. The purpose will be to identify lead agency services and resources for coordination at the regional level.

Continue to work on the implementation of recommendations of the Medicaid Managed Care Council Medical Home Work Group Report. The establishment of the Medical Home as the policy of CT's Medicaid Managed Care program will strengthen the Medicaid Managed Care program, be cost-effective, and better serve Connecticut's children.

DPH will meet with the two tertiary hospitals that provide specialty services for CYSHCN to focus on issues and concerns and develop linkage to the RMHSCs and MH.

Performance Measure 04: *The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective				61.3	61.3
Annual Indicator			61.3	61.3	61.3
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	61.3	61.3	61.3	61.3	61.3

Notes - 2002

Source: SLAITS, 2002

Notes - 2003

The data reported in 2002 from the national SLAITS Survey have pre-populated the data for 2003 for this performance measure.

Notes - 2004

The data reported in 2002 from the national SLAITS Survey have pre-populated the data for 2004 for this performance measure.

a. Last Year's Accomplishments

Data from the State and Local Area Integrated Telephone Survey (SLAITS) conducted between October, 2000 and April, 2002 indicated that in CT, 61.3% (95% CI 57.0, 65.6) of the families of children with special health care needs have adequate private and/or public insurance to pay for the services/equipment they need. CT met this objective.

Benefit specialists located at each CSHCN Center identified other sources of payment for which families may qualify for as well as coordinate their existing benefits and services. The percentage of families with a source of private/public insurance at the Centers is 91.6%, approximately a 4.5% decrease from the previous year.

The Medical Home Learning Collaborative (MHLC) identified the need to access reimbursement for care coordination activities as a value added service to CYSHCN. The Legislative Medicaid Managed Care Council Liaison and the Managed Care Ombudsman were

invited to the MHLC meetings to learn about the impact that utilizing the CSHCN Screener has had on improving the medical home for serving CSHCN and to discuss options in seeking reimbursement for the service time necessitated by the coordination of care activities.

The Medicaid Managed Care Liaison was invited to join the CT team in attending the Champions for Progress Center training as a key stakeholder. The training focused on tools to design statewide systems to address the level of coordinated, comprehensive, community-based care children with special health care needs require.

The legislated Medicaid Managed Care Council convened a working group of agency representatives, managed care organizations (MCO), pediatricians, and children's advocate to discuss the development of care coordination and medical home services for children and youth with special health care needs who are served by CT's Medicaid Managed Care plans (HUSKY) to assure access to needed services.

United Way of CT /2-1-1 Infoline Child Development Infoline (CDI) serves as the centralized point of entry for all CYSHCN and works closely with HUSKY Infoline to assure children have access to insurance. Please see Section E, State Agency Coordination for additional information.

The CT Medical Home Academy (MHA) will provide training to improve care for all CT children and youth, including access to needed health insurance. Please see Section E, State Agency Coordination for additional information.

To enhance the organization of easily accessible community-based service systems including access to adequate health insurance for needed services, DPH is developing public/private partnerships with others who serve the same population. DPH staff participated and will continue to work on legislated councils (i.e. Family Support Council, Interagency Coordinating Council, Medicaid Managed Care Council).

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Assess family?s insurance status		X		
2. Provide education on benefits/services provided by insurance/other programs				X
3. RMHSC and Medical Homes identify CYSHCN and provide care coordination including access to private/public insurance.		X		
4. Coordinate with HUSKY Infoline		X		
5. Work with Medicaid Managed Care Council and DSS to ensure cyshcn population is identified, provided all needed services, and providers are reimbursed for identification and care coordination services.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

CSHCN Centers and Medical Home support staff assist families of children and youth with special health care needs in assuring they have adequate insurance to pay for the services they need while providing coordinated, comprehensive, accessible, culturally-competent, community-based care. The RMHSCs and Medical Homes are enhancing the ability to serve families of CYSHCN with comprehensive, accessible, coordinated care including access to insurance to pay for needed services.

Medicaid Managed Care Council, Medical Home Work Group Report was completed in April 2005. The Work Group felt that Medical Home services can provide real benefit to children with special health care needs and their families, and that there is an added benefit to having those services provided at the primary care level. Summary of recommendations included that DSS screen all children and youth as part of EPSDT for special health care needs using a standardized definition, provide reimbursement for the time associated with identification and care coordination of CYSHCN, and develop uniform standards for Managed Care Organizations case management eligibility, care coordination services, and primary care provider care coordination billing and reimbursement procedures.

The MHA was introduced and the importance of reimbursement for care coordination services for children and youth with special health care needs was presented to all in attendance. Please see Section E, State Agency Coordination for additional information.

DPH has partnered with Elkinson and Sloves to develop a marketing feasibility analysis and action plan to support the expansion of the Medical Home concept. See website (http://www.dph.state.ct.us/BCH/Family%20Health/cyshcn/cyshcn-medical%20home%20site.htm) for additional information.

DPH is working to provide a tool for medical homes to report and manage records of CYSHCN, to ensure DPH has an accurate record of families who have adequate public and/ or private insurance to pay for the services they need. Please see website listed above for additional information.

DPH staff is developing Memoranda of Understanding (MOU) to work with the Department of Mental Retardation, the Department of Education, the Department of Children and Families, and the Department of Social Services in order to address issues regarding coordination of care, data sharing for all Connecticut families. Access to health insurance for needed services will be key component of the project.

The Family Health Section at DPH has received funding from the U.S. Department of Health and Human Services to launch Early Childhood Partners (ECP). The ECP process will ensure all children are healthy and ready to learn by age five. Please see Section E. State Agency Coordination for additional information.

c. Plan for the Coming Year

The Regional Medical Home Support Centers and Medical Homes will enhance the statewide implementation of the system to serve families of children and youth with special health care needs with comprehensive, accessible, coordinated care including access to adequate public and or private insurance to pay for services families need. The statewide roll out of the Medical Home System will be complete.

Early Childhood Partners will work to implement their plan to create an integrated service system that incorporates comprehensive health services, early care and education, and family support and parent education to ensure the sound health and full development of all children. The system will provide for easy entry, clear navigation, and appropriate supports for all families.

The recommendations of the Medicaid Managed Care Council Medical Home Work Group Report will continue to be implemented. The establishment of the Medical Home as the policy of CT's Medicaid Managed Care program will strengthen the Medicaid Managed Care program, be cost-effective, and better serve Connecticut's children.

Performance Measure 05: *Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective				76.8	76.8
Annual Indicator			76.8	76.8	76.8
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	76.8	76.8	76.8	76.8	76.8

Notes - 2002

The 2002 indicator is based on the State estimates from SLAITS.

Notes - 2003

The data reported in 2002 from the national SLAITS Survey have pre-populated the data for 2003 for this performance measure.

Notes - 2004

The data reported in 2002 from the national SLAITS Survey have pre-populated the data for 2004 for this performance measure.

a. Last Year's Accomplishments

Data from the State and Local Area Integrated Telephone Survey (SLAITS) conducted between October, 2000 and April, 2002 indicated that in CT, 76.8 % (95 % CI 71.1, 82.4) of community-based service systems are organized so families can use them easily. This percentage is slightly higher, but statistically similar to the national estimate of 74.3 % (95% CI 72.9, 75.7). CT met its objective for this measure.

Findings from the CT CYSHCN Needs Assessment Study were released, including a process evaluation of the pediatric practices participating in the Medical Home Learning Collaborative (MHLC) to document the developmental process. Results from this study were utilized to develop the Medical Home Academy (MHA) and to support the statewide spread of medical

homes for CYSHCN.

The top services families needed as identified by a statewide needs assessment study were identified as: 1) planned respite, 2) emergency respite, 3) after school program, 4) summer camps and 5) personal home care attendants. As a result, the two CYSHCN Centers were provided with additional respite and campership funds to assist families in meeting these needs.

CT DPH worked with stakeholders to design a new system of care. This system would provide coordinated community-based for CYSHCN. A request for proposals was released to solicit applications for organizations to serve in The CT RMHSC System of Care for CYSHCN and their caregivers.

The Child Development Infoline (CDI) began serving as the centralized point of entry for all CYSHCN in the new system of care. CDI developed and implemented a referral and coordination of services model which they now use to assess and refer appropriate CYSHCN and their families/caregivers to the RMHSC responsible for the region in which the family resides. This initiates the process of care coordination.

DPH program staff, CDI, and staff from the 2 CYSHCN Centers initiated monthly quality assurance meetings. These meetings served as a forum to establish improved communications regarding levels of care coordination and tracking of referral patterns of CYSHCN and their families/caregivers.

The CT MHLC developed following participation with the National Initiative for Children's Health Quality. These practices provided care coordination and increased the ease at which families can get their child's needs met through community based service systems. Meeting bimonthly, the MHLC supported the vision of enhancing CYSHCN by establishing regional Centers. The ongoing expected outcome of this MHLC is to increase family satisfaction, decrease worry, provide a central contact for information and referral, and decrease hospitalizations and emergency room visits.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Operationalize the Medical Home Support Centers to assist families with access to community based service systems.		X		
2. Implement medical home concept statewide to access community based, culturally sensitive services				X
3. Create information sharing and linkage opportunities between Infoline and the medical homes		X		
4. Maintain ongoing partnership with stakeholders.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Five applicants were chosen in response to the request for proposals to solicit applications for organizations to serve as CT RMHSCs System of Care for CYSHCN and their Families. These Centers will provide care coordination services with a focus on those identified with high complexity needs.

The MHLC expanded from 3 to 8 practices. The MHLC continues to meet quarterly to support practice improvement activities for care coordination. The MHLC continues ongoing identification of the issues and needs of the medical home community.

United Way of CT 2-1-1 Infoline/Child Development Infoline (CDI) is developing and implementing a referral and coordination of services model which serves to assess the needs and refer CYSHCN and their families/caregivers seeking additional support and services to the RMHSC and other services within CT. This system will serve as an access point and data management system for the CYSHCN section of CDI.

DPH program staff, Infoline/CDI, and staff from the two CYSHCN Centers continue their monthly quality assurance meetings. These meetings serve as a forum to establish improved communications regarding levels of care coordination and tracking of referral patterns of CYSHCN and their families/caregivers.

DPH is developing public/private partnerships with others who serve the same population. DPH staff participated and will continue to work on legislated councils (i.e. Family Support Council, Interagency Coordinating Council, and the Medicaid Managed Care Council). DPH staff are developing MOUs with CT agencies DMR, SDE, DCF and DSS to address issues regarding family access to community-based service systems.

The Department developed a public awareness campaign to raise family and professional knowledge of the resources available to CYSHCN and their families/caregivers. This was based on extensive interviews with families of CYSHCN, health care providers, employers and payers. Resources produced included: a CYSHCN/Medical Home website, a quarterly Medical Home Town Newsletter, national/state/local presentations, multiple printed resources available for distribution, and presentation of the MHA for pediatric physicians, nurses, other allied health professionals, and families. Media sources have begun requesting information to focus public attention on medical home and CYSHCN.

DPH, through its partnership with the Child Health & Development Institute, contracted with the University of CT Area Health Education Centers (AHEC) to develop and implement an MHA for pediatric health care providers and families. The curriculum of the MHA will help ensure that providers are knowledgeable and skilled at providing services to CYSHCN in the State.

The Department is the lead agency on the CT Early Child Partnership (ECP) (formerly known as the CT Early Childhood Comprehensive Systems [CECCS] Initiative) and is drafting a strategic plan to address the five domains of the CECCS that impact young children's health and learning.

c. Plan for the Coming Year

The DPH CYSHCN program will continue to expand the Medical Home Initiative. Primary care practices focused on pediatrics will be recruited by the RMHSC and educated in the Medical Home concept in order to enhance their capacity to serve CYSHCN and their families/caregivers. DPH will continue to develop the capacity for Infoline to serve as the central point of entry and repository of information and referral resources for CYSHCN and their families/caregivers.

The Department, together with the University of Connecticut's A.J. Pappanikou Center for

Developmental Disabilities, Birth to Three Program, the Department of Children and Families, and the Office of Child Advocacy, will plan an approach to create a state vision and training on care coordination. The Department will implement the Regional Medical Home Support Centers Systems of Care for CYSHCN to support access to community based, culturally sensitive services

ECP will field test and obtain stakeholder feedback about the strategic plan and develop a statewide ECP Implementation Plan.

Performance Measure 06: *The percentage of youth with special health care needs who received the services necessary to make transition to all aspects of adult life. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective				5.8	5.8
Annual Indicator			5.8	5.8	5.8
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	5.8	5.8	5.8	5.8	5.8

Notes - 2002

Source: SLAITS, 2002

Notes - 2003

The data reported in 2002 from the national SLAITS Survey have pre-populated the data for 2003 for this performance measure.

Notes - 2004

The data reported in 2002 from the national SLAITS Survey have pre-populated the data for 2004 for this performance measure.

a. Last Year's Accomplishments

Data from the State and Local Area Integrated Telephone Survey (SLAITS) conducted between October, 2000 and April, 2002 indicated that in CT, 5.8 % (95 % CI 0.6, 6.4) of CYSHCN received the services necessary to make transitions to adult life. This percentage is similar to the national estimate of 5.8 % (95% CI 4.6, 7.0). However, the number of families in CT who responded positively to this question was too low (N=6) to consider this estimate a valid representation.

The CYSHCN Centers provided transition services to youth age 15-18 and their caregivers.

Individualized meetings are conducted and families are provided with information on all aspects of transition including educational, vocational and transition to adult medicine. In order to ensure a coordinated transition effort, Center staff collaborate with schools and community based organizations. Staff were also involved with task forces and committees that focus on transition including the Transition Task Force of the Department of Education Bureau of Special Education and Pupil Services.

In their Annual Reports, the 2 CYSHCN Centers were asked to report the top 3 barriers to successful transition for youth. Responses included: health providers' lack of knowledge, inadequate training of health providers, inadequate transition medical summaries, insufficient time, limited staff, inadequate reimbursement for the transition services, inconsistent insurance coverage and lack of adult health care providers; the severity of the medical condition and the cognitive abilities of the child complicate the process; inadequate support systems; inadequate home and community accessibility; lack of availability of group homes; lack of available resources within DMR; lack of adult physicians appropriately trained who are willing to accept Medicaid rate reimbursement.

The 2 CYSHCN Centers were also asked to provide a list of ways to improve successful transition for youth. Responses included: more handicapped accessible housing; improve quality and quantity of group homes; increase Medicaid rates; ensure ongoing medical plan; promote adolescent's capacity for self-advocacy and self-determination; improve communication between specialists, primary care providers and families; address service gaps.

The Sickle Cell Disease Association of America/CT Chapter conducted a transition program to assist adolescents to make a smooth transition from pediatric to adult primary care/hematology providers by providing them with the knowledge and skills necessary to navigate in an adult-centered medical environment. Community awareness and provider education are other key components of the program.

CT Family Voices supports KASA, Kids As Self Advocates, which promotes and improves the lives of CYSHCN through peer empowerment and advocacy and the development of leadership opportunities. KASA had three meetings and provided a presentation about the organization at the statewide Together We Will Conference.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Identify youth with special health care needs.			X	
2. Identify and strengthen relationships with schools, community based organizations & State Agencies.				X
3. Provide children and families individualized transition packets.		X		
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The staff at the two CSHCN Centers continue to address the transition needs of YSHCN and their families/caregivers. During this year the Centers moved to initiating transition plans for youth by age fourteen (14) to be in compliance with the MCHB Six Performance Outcomes.

The DPH, through its partnership with the Child Health & Development Institute, contracted with the University of Connecticut Area Health Education Centers (AHEC) to develop and implement a Medical Home Academy (MHA) for pediatric health care providers and families. The curriculum of the MHA will help ensure that providers are knowledgeable and skilled at providing children and youth in the State of Connecticut and their families/caregiver with transition plans that are family-centered, community-based, comprehensive and coordinated.

The Department initiated expanded Adolescent Health Initiatives. This work included meeting with medical providers who are experts in adolescent health as well as several who specifically work with YSHCN and transition them to adult health care. It is becoming increasingly evident that there is a growing need to identify and educate adult primary care providers regarding the health care needs of YSHCN who may be entering their practice.

DPH staff is developing MOUs to work with the Department of Mental Retardation, the Department of Education, the Department of Children and Families, and the Department of Social Services to address issues regarding access to community-based service systems. This activity will facilitate the successful inter-agency coordination of transition for YSHCN.

The Department is co-sponsoring an interagency conference to strengthen the transition skills of YSHCN and their families/caregivers. "Moving Through Life Changes: Individuals and Families Leading Self-Determined Lives" will occur June 2005. Topical workshops will cover self determination and effective self-advocacy, models of family support, community partnerships, resources, health, special education, behavioral health, financing, legal issues, communication and, more. DPH staff will be attending to share information on the new Regional Medical Home Support Center System of Care for CYSHCN and their families/caregivers.

The Hospital for Special Care was granted funds to conduct a state wide needs assessment regarding Sickle Cell disease. This program will focus on transition services by addressing education for healthcare providers.

c. Plan for the Coming Year

The Regional Medical Home Support Center System of Care will continue to support YSHCN in all aspects of adult life as they transition into the adult community. The Medical Home Learning Collaborative will continue to pursue YSHCN transition educational resources through updates on the Ticket to Work Program, Vocational Rehabilitation and KASA.

DPH staff will actively promote interagency collaboration with the Department of Mental Retardation, the Department of Education, the Department of Children and Families, and the Department of Social Services in order to address issues regarding access to community-based service systems. This activity will facilitate the successful inter-agency coordination of transition for YSHCN.

The Department will continue to pursue expanded Adolescent Health Initiatives. This work will include meeting with an advisory group of a broad array of service providers and consumers with adolescent interests; this will include several who specifically work with YSHCN and transition them to adult health care. The Department will be vigilant for the growing need to identify and educate adult primary care providers regarding the health care needs of YSHCN who may be entering their practice.

Performance Measure 07: *Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	90	90	90	82	91.4
Annual Indicator	88.0	82.0	78.0	91.1	92.4
Numerator	76374	71373	67372	78103	79216
Denominator	86789	87040	86374	85734	85732
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	92.8	93.2	93.6	94	94

Notes - 2002

Source: Centers for Disease Control N.I.S. data 2001 survey for 4: 3: 1: 3: 3:. Note the % has decreased due to increase in shots tracked. CT still is a leader among states for immunization success rate. (Numerator & Denominator are census projections based on the percentage derived from the National Immunization Survey data.)

Notes - 2003

Source: Centers for Disease Control N.I.S. data 2002 survey for 4: 3: 1: 3: 3:. CT ranks #1 among states for immunization success rate. Denominator represents CY 2000-2001 resident births. The numerator is not an actual #, but a synthetic estimate based on the percentage derived from the National Immunization Survey Sampling data of children with DOB 8/99-11/01.) Web source: http://www.cdc.gov/nip/coverage/nis/02-03/tab03 antigen state.xls

Notes - 2004

Source: Centers for Disease Control N.I.S. data Q32003-Q22004 survey for 4: 3: 1: 3: 3:. CT ranks #1 among states for immunization success rate. Denominator represents CY 2001-2002 resident births. The numerator is not an actual #, but a synthetic estimate based on the percentage derived from the National Immunization Survey Sampling data of children with DOB 8/00-11/02.)

a. Last Year's Accomplishments

According to the Centers for Disease Control National Immunization Survey for 2004, 92.4 (+/- 3.7) percent of children age 19 - 35 months have complete immunizations in Connecticut (http://www.cdc.gov/nip/coverage/NIS/03-04/toc-0304.htm). CT exceeded its goal of 91.4 percent. This percentage represents better immunization coverage than the national percentage of 80.5 (+/- .9 percent). The percentage reported is based a telephone survey of reported vaccinations on records for the 5 reportable vaccines. Based on the current NIS data, CT, for the second year in a row, ranked the highest of all states in immunization levels for young children with the highest national immunization coverage rate on record and continues to

remain a leader in pediatric immunizations. The national percentage of children age 19 - 35 months receiving the combined vaccine series 4:3:1:3:3 increased from 2003 to 2004.

Twelve Community Health Center corporations provided preventive and primary health care to children at thirty-five sites. Four of the centers received funding under the Pediatric Primary Care project and serve children not eligible for other insurance programs. All centers follow national guidelines for administration of childhood immunizations. Chart reviews are used to assure that infants and children are in compliance. For FY 2004, 93% of the children 24-35 months of age served by the four pediatric primary care projects were immunized in accordance with AAP standards.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Monitor infants and children for compliance with immunization schedules.	X			
2. Outreach and identify infants and children for up to date immunizations.		X		
3. Provide support, information and linkage to necessary services.		X		
4. Procure and provide publicly purchased vaccines.		X		
5. Provide funding & technical support to health care providers to improve childhood immunization levels		X		
6. Provide WIC check box to identify up to date immunization status.			X	
7.				
8.				
9.				
10.				

b. Current Activities

A number of Title V funded and non Title V programs promote age appropriate immunizations. Right From The Start, Comadrona, Healthy Start and Healthy Choices for Women and Children provide case management to pregnant women and their children, monitor, encourage and educate parents regarding the importance of keeping well child care visits. The programs assess immunization status and link children with primary care providers to maintain up-to-date immunizations.

CSHCN assesses children for required immunizations and refers them to appropriate resources. Care coordination is used to support families in accessing services.

The WIC Program continues to encourage parents and caregivers to obtain well child care and refers participants to eligible programs. The CT WIC certification form includes a check-off box for the health care provider to indicate if the child is up-to-date on immunizations, which then enables the WIC nutritionist to reinforce the importance of obtaining missed immunizations.

The Immunization Program provides funding to support the Connecticut Immunization Record Tracking System (CIRTS) and provides funding to 19 contractors to conduct immunization activities, procure and distribute publicly funded childhood vaccines. Contractor activities consist of performing clinic immunization assessments to monitor immunization coverage rates for preschool children, coordinate and provide outreach and referrals for children identified by

CIRTS as being behind in their immunizations, conduct immunization education campaigns that are culturally appropriate to target pregnant women, new parents, new immigrants and provide training and support to providers who utilize the CIRTS.

c. Plan for the Coming Year

The Title V funded and non-funded programs, including Children With Special Health Care Needs, WIC, Community Health Centers and those that provide case management services to pregnant women will continue their efforts described in the Current Activities Section. Provision of immunizations as part of well child care is a recognized important component of protecting public health.

The immunization program plans to continue to assess and monitor immunization rates including HEDIS immunization rates for children enrolled Medicaid Managed Care, continue to convene local advisory/planning groups in all 19 Immunization Action Plan funded sites to improve immunization services for children in high risk areas, continue to partner with community organizations, coalitions, businesses and public and private professional and civic organizations to promote childhood immunizations and vaccine safety.

Performance Measure 08: *The rate of birth (per 1,000) for teenagers aged 15 through 17 years.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	17.9	16.6	16.1	14	14
Annual Indicator	16.7	16.2	14.0	12.9	
Numerator	1077	1044	982	906	
Denominator	64362	64362	69947	69976	
Is the Data Provisional or Final?				Provisional	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	12.9	12.9	12.8	12.8	12.8

Notes - 2002

Source: CT Dept of Public Health, Vital Statistics 2001

Notes - 2003

CDPH Vital Statistics for Connecticut are provisional for 2003 at this time. We do not anticipate having final 2004 data until a year from now.

Notes - 2004

We do not anticipate having final 2003 and provisional 2004 data until a year from now. The 2004 annual objective field is "locked in" from last year and will not allow us to change the objective to reflect our most recent experience. If we were able to change this field we would

have modified the objective for 2004 to read 12.9 NOT 14.0 which would be a goal in the OPPOSITE direction to an improved experience.

a. Last Year's Accomplishments

In CT for 2002, there were 906 births among the estimated 69,976 females age 15 to 17 for a birth rate of 13 per 100,000. This is an improvement from the 2001 rate of 16.2 per 100,000 (1,044 births among the estimated 64,362 females age 15-17). CT met its targeted objective of 14. Much of its success can be attributed to a renewed emphasis on prevention of teen pregnancy in general, concomitant with an intense focus on the prevention of repeat pregnancies. This has been achieved through the use of behavioral risk assessments for adolescents, comprehensive case management, referral and follow up for reproductive health care including comprehensive services. These core services are provided in all Title V programs serving teens.

The Abstinence-Only Education program provided education and skills development on making healthy lifestyle choices, developing effective communication skills, setting future goals, attaining self-sufficiency before engaging in sexual activity, and rejecting unwanted sexual advances. A post participation survey demonstrated changes in views on sexual behavior and an increased understanding of abstinence as the only way to prevent pregnancy and sexually transmitted diseases (STDs). Program activities were sustained in one community. The program initiated a media campaign to promote public awareness about teen pregnancy prevention, featuring the State's newest comprehensive teen-friendly website, www.ctnow.com/teens, which was maintained for approximately six months. The cornerstone of the media campaign was "Teens Sing Out," a unique jingle-lyrics writing contest for middle school students, 5th through 8th grade.

Central Area Health Education Center convened an Advisory Committee to develop a State Perinatal Plan. The advisory committee reviewed information on current teen pregnancy prevention programs in the state. One of the goals identified in the plan was the reduction of pregnancies and poor birth outcomes among adolescents.

SBHCs conducted an RFP process to identify a contractor to organize an advisory committee with the intent of developing a State Adolescent Health Plan including collection of CT specific data on reproductive health issues for teens. The planning process was implemented during the current year's activities (see below).

The Right From The Start Program provided intensive case management services to 347 pregnant and/or parenting teens. This demonstrated an increase of 55 clients from the previous year.

The FHS established CT Youth Health Service Corp to promote teen pregnancy prevention by engaging youth in activities that promote healthy behaviors and lifestyles and also support workforce development by facilitating the transition of youth from school to employment in the health care field particularly with underserved populations (i.e. homeless persons). This project is co-funded by the UConn Area Health Education Center and is in partnership with the CT Primary Care Association.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide risk assessment and referral for reproductive health services.	X			
2. Support teen pregnancy prevention programs.		X		

3. Collaborate with local and statewide initiatives.			X	X
4. Link teens with related life skills, education, and advocacy programs.				X
5. Plan and implement public awareness campaigns to promote positive youth development.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Perinatal programs including Comadrona, Healthy Start, Right From The Start Program, and Healthy Choices for Women and Children (which serves both teens and adults) provide support, information and linkages to services for teen parents and places heavy emphasis on preventing subsequent teen pregnancies by providing intensive case management services and linking clients with educational, health and social services, education in life skills, and family planning.

SBHCs provide age-appropriate reproductive health education to students identified as being high risk for sexual activity. Students who tested negative for pregnancy were provided reproductive health education and referrals for contraceptive services. An Adolescent Health Advisory Body was established to develop the Adolescent State health Plan. Of the critical elements identified is the prevention of teen pregnancy.

The Perinatal Advisory Committee met during the year and the final draft of the plan has been submitted to the department for review and approval. One of the identified goals in the plan is the reduction of teen pregnancies and poor birth outcomes among adolescents.

Staff attended a meeting convened by JSI, to share best practices and state programmatic information regarding teen pregnancy prevention programs. Staff convened a follow up conference call with JSI regarding JSI's ability to provide technical assistance to CT as part of their 5-year CDC grant.

The Family Planning Program (FPP) provides comprehensive reproductive health care services, education and counseling regarding sexual decisions, pre-contraceptive counseling, contraceptive methods and pregnancy testing and referral to prenatal care providers.

Abstinence-Only Education provides skills development on making healthy lifestyle choices, developing effective communication skills, setting future goals, attaining self-sufficiency before engaging in sexual activity, and rejecting unwanted sexual advances. The winning lyrics from "Teens Sing Out," which was initiated in 2004, will be the basis of 60-second radio spots that are scheduled to air on teen radio stations statewide the Summer 2005.

Community Health Centers provide behavioral risk assessments for sexual active adolescents age 12-19, to be used to develop treatment plans. CHCs continue to utilize EPSDT guidelines to provide reproductive health care including contraceptives, STD diagnosis and treatment.

The CT Youth Health Service Corp identified 6 sites for implementation: Hartford, Waterbury, Bridgeport, New Haven, Danbury and Stamford. 120 participants are currently enrolled which exceeded the anticipated number of 60 during the first year's activities. Students are placed at 20 volunteer worksites sites consisting of homeless shelters, community health centers and assisted living facilities with 150 hour volunteer hours contributed.

c. Plan for the Coming Year

The Title V funded and non-Title V programs including Right from the Start, School Based health Centers, Healthy Choices for Women and Children, Family Planning, Healthy Start, Abstinence-Only Education and Community Health Centers will continue efforts described in the Current Activities section that direct their activities to adolescents to reduce unintended pregnancies among teens.

The Family Health Section will utilize the newly identified Perinatal and Adolescent State Health Plans to address program development. Reproductive health has been identified as a priority in the developing Adolescent Plan. Draft recommendations of the Adolescent State Health Plan identified teen pregnancy prevention as a priority need to be addressed by a sub-committee to sustain the initial planning process and develop ongoing activities. The Perinatal State Health Plan identified as one of its goals to reduce pregnancies and poor birth outcomes among adolescents. Seven strategies were identified to address this goal and will be implement based upon available resources.

DPH will work collaboratively with JSI to assess the feasibility of reconvening the State Teen Pregnancy Prevention Coalition.

Staff will work collaboratively with AHEC, CPCA and the Office of Workforce Development to identify future funding to sustain and enhance the CYSHCN program.

Performance Measure 09: *Percent of third grade children who have received protective sealants on at least one permanent molar tooth.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	35	30	30	26	30
Annual Indicator	26.0	26.0	26.0	26.0	
Numerator	357	357	357	357	
Denominator	1374	1374	1374	1374	
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	30	30	30	30	30

Notes - 2002

Source: This data is from SFY2000 Oral Health Sruvey, CT DPH.
Revised data may become available when future funding allows for another survey.

Notes - 2003

Data for this measure requires a state survey of third grade children.
CT has no new data since the last such survey was funded SFY2000.

Notes - 2004

Data for this measure requires a state survey of third grade children.
CT has no new data since the last such survey was funded SFY2000.

a. Last Year's Accomplishments

A primary goal of the DPH Oral Health unit is to centralize, coordinate, enhance and integrate oral health data, and information systems, in part, to monitor the prevalence of dental sealants. The Family Health Division reorganized in 2003 to include a Surveillance, Evaluation and Quality Assurance unit, which will enable DPH to better monitor the prevalence of dental sealants.

DPH dental contract spending plan for dental services in FY 2004 included 4 School Based Health Centers (SBHCs) and 4 Community Health Centers (CHCs). However, it is up to the discretion of each site on how this money is used. Limited data is received from these SBHCs, CHCs and other dental safety net facilities and the dental data reporting is often incomplete, inconsistent, and not comparable. The State of CT has not been able to measure the prevalence of dental sealants for NPM#9, due to the issues regarding data collection, quality, and reporting.

In an Oral Health Survey and Needs Assessment (OHSNA) study conducted in Connecticut in 1995-1997, twenty six (26) percent of all 3rd grade school children surveyed were found to have dental sealants. This was a good source of data for this performance measure; however, there has been no funding for a follow-up survey.

In the fall of 2002 $125,000 of state funds was awarded to 5 sites ($25,000 each) to increase placement of sealants in children over and above the population they were currently serving. Due to the short period for expending this funding (6 months), and unavailability of continuation funding, the effectiveness and outcomes of the project could not be evaluated.

DPH developed and distributed two educational brochures that were very successful. One of them was geared to parents and caregivers of small children and discusses the importance of early dental visits and how to navigate the system to receive dental care. Over 10,000 copies were requested from various groups across the state. The second brochure was developed and distributed to all physicians and nurse practitioners in the state and discussed the latest on the relationship between systemic and oral diseases. Mailing of this brochure resulted in renewed interest in OPENWIDE trainings and DPH received several calls to set up training sessions.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Develop a strategic plan for enhancing DPH data and information systems to improve the monitoring of dental sealants? prevalence.				X
2. Continue OPENWIDE training of non-dental providers.				X
3. Convene workgroup to address barriers/issues regarding billing of dental procedures in public health facilities				X
4.				
5.				

6.				
7.				
8.				
9.				
10.				

b. Current Activities

The Oral Health Unit lost two of the three staff members in this unit during the year. The state oral health director position has recently been filled and there are currently two staff vacancies. This has affected current activities for achieving this measure. As of 09/04, there was no staffing the Oral Health unit. Another reorganization occurred at DPH that resulted in the establishment of the Office of Oral Public Health, to show Connecticut DPH's commitment to increasing access to comprehensive dental care for this target population.

The Office of Oral Public Health has partnered with several key stakeholders to develop a comprehensive state oral health plan This advisory group for the state oral health plan includes representation from public health facilities.

DPH has been rolling out OPENWIDE, a statewide oral health-training program for non-dental health and human service providers on the importance of oral health to general health and well-being. Priority continues to be training non-dental providers who work with children age 0-5 years.

The DPH collaborated with the CT Chapter of ACOG and disseminated a survey to 800 licensed Obstetricians in the state to determine current practices concerning oral health and ascertain their level of interest in participating in an OPENWIDE training. While the response rate was low and not generalizable, the survey did yield some useful information, such as respondents' willingness to work with DPH further on this project. However, this initiative too, had to be put on hold, due to lack of staff.

The 2004 Behavioral Risk Factor Surveillance System (BRFSS) telephone survey, sponsored by the CDC, contains state-added questions on if the children in the household have ever had sealants. Data should be available next year.

Staff submitted and was awarded a HRSA grant to support a CT Sealants program. This 3 year grant will provide the infrastructure to promote the placement of sealants in school aged children but is in jeopardy as activities are not able to be conducted.

The DPH has issued an RFP for a consultant to evaluate the OPENWIDE curriculum. The evaluation will consist of interviews and surveys and assess the degree to which the information presented was effectively integrated in to various settings (Head Start, etc.). This project has also been put on hold due to staffing issues.

More than $2 million in funding to expand community access to dental care has been approved by the state Bond Commission. A total of $2,048,424 in bonding is planned for projects in 11 towns and cities, ranging from school- based dental clinics to mobile dental care centers. This too should further promote the placement of dental sealants.

c. Plan for the Coming Year

The Office of Oral Public Health is continuing the development of a comprehensive state oral health plan. There are plans to hire an Epidemiologist 2 staff person for the Office of Oral Health as part of the comprehensive plan enabling improved monitoring and reporting of the prevalence of dental sealants.

OPENWIDE training of non-dental professionals during the coming year will include more pediatricians, family practice physicians and nurses who also treat school age children. Preventive measures promoted for this group of children includes dental sealants. Therefore, we hope to see an increase is the number of sealants placed as a result of pediatricians, nurses and family practice physicians making appropriate referrals for dental care.

Performance Measure 10: *The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	0.8	0.8	1	0.7	0.7
Annual Indicator	1.1	1.0	0.7	1.5	
Numerator	7	7	5	11	
Denominator	666135	709075	729316	734933	
Is the Data Provisional or Final?				Provisional	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	0.9	0.8	0.7	0.6	0.6

Notes - 2002

Source: CT Dept of Public Health, Vital Statistics 2001

Notes - 2003

CT Department of Public Health, Vital Statistics, 2002.

Notes - 2004

We do not anticipate having provisional 2004 data until a year from now.
The form would not allow modification of the 2004 objective now based on our newly acquired data for 2003. If we had the opportunity to adjust this figure our objective for next year's reporting would be 1.0 representing a 33% improvement (downward direction) from the current 1.5 rate. The "locked- in" rate of .7 as an objective for 2004 would be a rather unrealistic 53% improvement compared to our most current rate.

a. Last Year's Accomplishments

In 2003 there were 11 deaths due to motor vehicle crashes among children aged 14 years and younger for a rate of 1.5 per 100,000. The annual performance measure objective of 0.7 per 100,000 was not met for 2003. Since 2000, the number of deaths in CT due to motor vehicle crashes in this population has varied from year to year (7 deaths in 2000, 7 deaths in 2001 and 5 deaths in 2002). Motor vehicle crashes are a major health risk for CT's children. Every year approximately 10,000 children aged 8 years and less are occupants of motor vehicles involved in crashes in Connecticut (CT DOT Crash File 1996 -- 2002). Motor vehicle crashes were

responsible for approximately 4,000 Emergency Department visits and 200 hospitalizations among children birth to 14 years of age (1999 Hospital Discharge Data, CT Hospital Association.) CT addresses this performance measure through Title V and non-Title V programs and collaborations that provide activities designed to reduce the number of deaths and injuries among Connecticut's children due to motor vehicle crashes.

Many Title V programs have worked to reduce the rate of motor vehicle crashes among children age 1-14. The Injury Prevention Program (IPP) worked closely with state and local partners to address motor vehicle safety among children. The IPP provided support for efforts to enact Booster Seat legislation although this bill did not pass during the 2004 session. Preventive Health and Health Service Block Grant (PHHSBG) funds were provided to 2 local health departments to conduct motor vehicle injury prevention programs. One local health department maintained a safe community coalition working towards environmental and policy changes with a specific focus on pedestrian safety. The Program worked with the CT Department of Transportation (DOT) and CT SAFE KIDS Coalition to provide booster seat educational materials to all pediatricians, and childcare providers in the state as well as MCH providers and Title V programs.

Comadrona, Healthy Choices for Women and Children and Right from the Start provided referrals and linkages to child safety seat and booster seat resources so that infants and children served were properly secured when riding in a motor vehicle.

Community Health Centers, as EPSDT providers, provided children and/or their caregivers age appropriate risk assessments, anticipatory guidance and injury prevention information related to motor vehicle safety.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide technical assistance, resources, and funding to support to motor vehicle injury prevention activities.			X	X
2. Provide linkages to motor vehicle injury prevention resources.			X	X
3. Provide screening, risk assessment and anticipatory guidance in Title V funded programs.	X			
4. Provide guidance and support for policy development regarding motor vehicle related mortality in children.			X	X
5. Participate in statewide coalitions and collaborations addressing motor vehicle injury prevention through public and professional education, policy change and system enhancements.		X	X	X
6. Utilize injury-related data to guide planning for state and community based programs and policy development.			X	X
7.				
8.				
9.				
10.				

b. Current Activities

The IPP collaborates with state and local partners to address motor vehicle injuries among children. There continues to be a major national focus on reducing motor vehicle injuries

among 4-8 years olds by increasing booster seat use, and DPH works with its partners to address this issue. Data from the Dept of Transportation (DOT) crash files indicate that 77% of children age birth to 3 years who were riding in cars involved in motor vehicle crashes were in child safety restraints, while only 16% of the 4 to 7 years olds were. DPH supported legislation during the 2005 session to improve CT's child passenger safety law to protect booster seat age children (up to age 7 and 60 lbs.)

DPH continues to provide funding to local health departments for injury prevention programs to conduct car safety seat clinics, child passenger safety programs, safety belt awareness activities, pedestrian and bicycle safety programs. Three local health departments have chosen this option this year. The IPP continues to provide technical assistance to other units within DPH and community programs. In collaboration with CT DOT, new child passenger safety videos in English and Spanish were provided to CHCs, Comadrona, HCWC, RFTS, Head Start Programs, Healthy Start Programs, Hospitals, childcare training organizations and associations. A series of child passenger safety workshops specifically targeting health care providers and childcare providers are being conducted throughout the state during the summer 2005.

The FHS received continuation funding from the National Highway Traffic Safety Administration (NHTSA) for CT's Crash Outcome Data Evaluation System (CODES). Funding will allow for purchase of hospital and ED data until 2009. The CODES project links police crash reports with death, hospital, and Emergency Department Data to provide a more comprehensive picture of motor vehicle crashes, injuries and deaths. This enhanced data set will be useful in planning and evaluating programs and policies aimed at reducing motor vehicle injuries in children and adolescents.

Comadrona, HCWC and RFTS provide referrals and linkages so that infants and children served are properly secured when riding in a motor vehicle. These programs are receiving new child passenger safety videos and will be invited to the child passenger safety workshops. HCWC provided car safety seats to clients who would not otherwise have been able to afford them.

CHCs, as EPSDT providers, provide children and/or caregivers age appropriate risk assessments, anticipatory guidance and injury prevention information related to motor vehicle safety. CHCs were invited to participate in the CT SAFE KIDS conference in September 2004. CHC staff are receiving child passenger safety videos in English and Spanish and are included in the child passenger safety training workshops.

SBHC professionals routinely offer motor vehicle safety information to students in the form of one-on-one meetings as well as group sessions.

c. Plan for the Coming Year

The Injury Prevention Program will work closely with the other FHS programs to integrate motor vehicle injury prevention into Title V and other children's programs throughout the Department including Day Care Licensing and Emergency Medical Services for Children. The IPP will continue to participate in the recently formed Virtual Children's Health Bureau to strengthen collaborations around injury prevention. Child transportation safety has been approved as one of the "Core Areas of Knowledge" defined by Connecticut Charts-A-Course (CCAC), the state wide professional development system for childcare. The IPP will be working with partners to develop a standard curriculum on this topic, which will then be included in the requirement for CCAC's Child Development Credential.

Resources and technical assistance will be provided to MCH programs, contractors, and communities on motor vehicle occupant, bicycle and pedestrian injury prevention. The IPP will

follow up on the child passenger safety training courses currently being offered to health care and childcare providers to determine if the information is being used and identify further training and resource needs. The IPP will continue its collaboration with other Title V programs, CT SAFE KIDS Coalition, CT Department of Transportation and other safety advocates to promote child passenger safety, especially the use of booster seats. Booster seat legislation is passed during the 2005 legislative session. The IPP will work with its partners to increase awareness and compliance with the new law. Passage of booster seat legislation may also make federal Transportation incentive funding available to CT. If this is the case, the IPP will work with CT DOT and partners to include Title V programs.

The FHS will use CODES data in the development and support of programs and policies that address the risk factors for motor vehicle injuries among children. An advisory committee of agencies and organizations concerned with motor vehicle injury prevention will be developed to help ensure the data are utilized at the state and local level.

Comadrona, HCWC and RFTS programs will work more closely with Injury Prevention Staff to enhance activities to reduce the death rate for children 14 and under caused by motor vehicle crashes. DPH will provide injury prevention materials to the state Healthy Start Programs.

SBHCs will continue to have motor vehicle safety as an integral focus of events and services. Community Health Centers, as EPSDT providers, will continue to provide children and/or their caregivers age appropriate risk assessments, anticipatory guidance and injury prevention information related to motor vehicle safety.

Performance Measure 11: *Percentage of mothers who breastfeed their infants at hospital discharge.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	69	69.3	69.4	73.2	73.2
Annual Indicator	67.8	69.3	73.2	72.9	73
Numerator	28923	29597	30741	31219	
Denominator	42660	42708	41996	42825	
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	73	73.1	73.2	73.3	73.4

Notes - 2002

Source: Mother's survey, Ross Products Division, Abbott Laboratories, Inc. Percent is derived from CY2001 mail survey sampling with numerator and denominator derived from projections to DPH birth data.

Notes - 2003

Source: 2003 CDC's N.I.S. reported percentage of 72.9 has a confidence interval of +/- 5.3% . Prior years' data source was Ross Labs. The N.I.S. data compares closely with Mother's Survey, Ross Products Division, Abbott Laboratories, Inc. for the same time period. Ross' percent of 69.4 is derived from CY2003 mail survey sampling.Numerator and denominator derived from projections to DPH birth data.

Notes - 2004

Source: 2003 CDC's N.I.S. has a confidence interval of +/- 5.3% compares closely with Mother's survey, Ross Products Division, Abbott Laboratories, Inc. Percent of 69.4 is derived from CY2003 mail survey sampling with numerator and denominator derived from projections to DPH birth data.

a. Last Year's Accomplishments

The estimated rate of breastfeeding in CT decreased from 73.2% to 69.4%; the state did not meet the projected goal of 73.2%. This is an estimate since the data are collected and reported by the Ross and Abbott Laboratories using their Mother' Survey. However, results of the National Immunization Survey indicated that the breastfeeding initiation rate in Connecticut for 2003 was 72.9%.

In celebration of National Breastfeeding Awareness month, DPH collaborated with CT Children's Medical Center to promote Breastfeeding Awareness and displayed a promotional banner outside the State Office Building. Materials were provided to Title V case management programs for pregnant women (HCWC, Healthy Start, Comadrona, RFTS). In an effort to reach all new parents, DPH purchased English/Spanish breastfeeding information sheets and placed them in hospital discharge packets mailed to new mothers. DPH maintained its collaboration with the CT Breastfeeding Coalition (CBC) by developing/distributing a survey to 2,286 providers (pediatricians, family practitioners, and OB/GYNS) to obtain baseline data regarding new mothers who breastfeed, as well as to identify provider training needs. Staff collaborated with the CBC to host a symposium "Strategies for Health Care Providers to Support Breastfeeding" targeting pediatricians, family practitioners, and OB/GYNS.

To address the racial and ethnic disparities in breastfeeding, staff issued an RFP to assess and determine the rationale for disparities in initiation and duration rates of breastfeeding in Black/African American women, and to develop a plan to promote breastfeeding in this population. To better address this federal performance measure, and to obtain population based data regarding breastfeeding, a question regarding new mothers' intent to breastfeed was added to the electronic newborn screening database.

Staff worked with a graduate nursing student from the UConn to develop provider and consumer breastfeeding information. The student conducted a literature search, reviewed existing breastfeeding materials and conducted focus groups of pregnant and parenting women at CHCs statewide in order to ascertain what types of materials were needed and not currently available.

The WIC program continued to promote breastfeeding to all pregnant participants unless medically contraindicated. The breastfeeding initiation rate among mothers enrolled in the WIC Program during their prenatal period rose slightly to 54% as of September 30, 2004, lagging behind the national target, with more than 70% of mothers ceasing to breastfeed by 6 weeks postpartum. The WIC Infrastructure Grant that was awarded to Connecticut by USDA, funded a project to assess local agency breastfeeding promotion and support activities. WIC was represented on the Breastfeeding Committee of the CT Chapter of the American Academy of Pediatrics (AAP) and the CBC. Each local program has a designated Breastfeeding Coordinator who participates in the committee.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Attend and participate in the monthly CBC meetings.				X
2. Identify and track breastfeeding data sources to further build infrastructure.				X
3. Promote provider and consumer education and awareness through training and education.				X
4. Implement recommendations of provider survey and consultant analysis of disparities in breastfeeding rates in African American women as appropriate.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

DPH is currently working with a consultant to assess and evaluate disparities in initiation and duration rates of breastfeeding in African American and black women in CT. This project involves literature search, focus groups, surveys, and recommendations for CT.

Comadrona, Right From The Start and WIC continue to provide support information and necessary services for mothers to initiate and maintain breastfeeding. As part of their contract requirements, Right From the Start requires promotion of breastfeeding to clients served by the program.

The State WIC office chairs a statewide WIC Breastfeeding Committee that comprises WIC Breastfeeding Coordinators from each local WIC Program. Local Breastfeeding Coordinators are responsible for local agency breastfeeding promotion and support activities. The WIC Program maintains an inventory of electric breast pumps that are issued to eligible women who are returning to work or school. USDA Breastfeeding Peer Counseling funding was awarded to the Connecticut WIC Program in October 2004. The program is in the process of implementing plans to expand the Breastfeeding: Heritage and Pride (BHP) breastfeeding peer counseling program that is jointly administered by the Hispanic Health Council and Hartford Hospital. This model will be replicated in other communities when additional funding becomes available. Guidelines for breastfeeding promotion and support are in the process of being finalized and a continuing education session for local WIC nutrition staff is scheduled for June 2005.

The PRATS survey data is currently being weighted by MACRO. This process is expected to be completed by July. The electronic newborn screening database began collecting information on breastfeeding from CT hospitals in January 2004 and data is available although incomplete. DPH staff are working with hospitals to obtain more complete data over time. DPH analyzed data from a survey sent to a total of 2,286 pediatricians, family practitioners, and obstetrician/gynecologists to obtain baseline data regarding the number of new mothers in the provider's practice who breastfeed and to determine provider training needs.

The CBC is hosting the second annual supper symposium in May entitled "Implementing the New American Academy of Pediatrics Breastfeeding Guidelines: Best Practice and

Reimbursement." The targeted audience is pediatricians, family practitioners, midwives, and lactation consultants. DPH will provide educational materials at this conference. The DPH continues to actively participate on the Board of the CBC and support their efforts and activities.

DPH collaborated with the CBC to develop and produce a one page educational document in English and Spanish on breastfeeding laws in Connecticut. This document is mailed to all new mothers along with some other breastfeeding materials.

c. Plan for the Coming Year

Recommendations from the consultant regarding addressing low breastfeeding rates in African American women will be reviewed and implemented as appropriate. The goal is to promote breastfeeding in the African American population in a culturally appropriate and sensitive manner.

DPH staff will continue to participate in monthly meetings of the CBC and the Breastfeeding Committee of the CT Chapter of AAP, as convened, to support and promote breastfeeding in CT.

Breastfeeding packets for providers and consumers that were developed in conjunctions with the University of Connecticut nursing student will be printed and distributed.

All DPH perinatal health programs will continue to provide breastfeeding support services as integrated in their case management activities.

Data from the Provider and PRATS surveys will be analyzed as resources are available and recommendations will be made in developing future activities regarding breastfeeding.

Current WIC breastfeeding promotion and support activities will continue, and efforts to improve the breastfeeding duration rate will be emphasized. The expansion of the Breastfeeding: Heritage and Pride (BHP) breastfeeding peer counseling program that is jointly administered by the Hispanic Health Council and Hartford Hospital will continue to be funded. Additional funds will be sought to replicate the BHP model in other communities. WIC Program staff will continue to participate in the CBC and the Breastfeeding Committee of the CT Chapter of AAP, and the WIC Breastfeeding Committee will continue to meet on a bimonthly basis.

DPH has designated a staff person, Susan Jackman, WIC Nutritionist as the DPH's Breastfeeding Coordinator. This position is co-funded by the MCHBG and USDA funds. This role will assist the DPH in becoming more visible in its efforts to promote breastfeeding statewide and assure the implementation of statewide activities from various surveys and needs assessment data.

Performance Measure 12: *Percentage of newborns who have been screened for hearing before hospital discharge.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004

Annual Performance Objective	95	96	95	97	99.9
Annual Indicator	45.5	93.0	96.9	100.0	98.0
Numerator	19594	39266	41347	41852	41696
Denominator	43020	42231	42655	41868	42545
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	98.2	98.4	98.6	98.9	99

Notes - 2002

Source: CY2002 Newborn Screening program data matched with EVRS and AVIS system. No data available for prior years1998 and 1999 since the program started in 2000.

Notes - 2003

CY2003 CT Newborn Screening Program data matched with EVRS and AVIS system. No data available for 1999 or prior as the program started in 2000.

Notes - 2004

CY2004 CT Newborn Screening Program data matched with EVRS and AVIS system. The newborn hearing screening program started in 2000.

a. Last Year's Accomplishments

In 2004, the Universal Newborn Hearing Screening (UNHS) program received data on 41,696 infants from the 30 birthing facilities the data received, 98% of the infants were screened for hearing loss before discharge. This exceeded our objective of 96%.

The average age of diagnosis of an infant with a hearing loss was 2.29 months. Families of infants with hearing loss are referred to the CT Birth to Three System for an early intervention at the time of diagnosis. The average age of enrollment into early intervention was 3.76 months. Infants with a bilateral, 40 dB or greater hearing loss, are automatically eligible for services.

The UNHS program manager conducted pediatric Grand Round presentations, in conjunction with the University of CT, Division of Human Genetics, to educate providers about infant hearing loss and genetics in Newborn Screening.

Newborn Hearing Screening staff conducted a one-day educational conference ?Newborn Screening in Public Health' with staff from the 29 birth hospitals. It included presentations on infant hearing, genetics, laboratory and birth defects in newborns. It also provided an opportunity to train hospital staff on enhancements that were made to the internet-based reporting system. The enhancement was completed in January 2004 and includes provisions for birth hospitals to report data on infants with risk factors for hearing loss and any birth defects or special health care needs that may be present at birth. An electronic technical assistance manual was developed to guide hospitals through the reporting process.

DPH staff conducted site visits to hospitals as needed and/or with any change in nurse manager positions, and provided technical assistance to the 30 birthing facilities, as needed.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Improve state data tracking system.				X
2. Improve follow-up on missed or abnormal screens.				X
3. Improve follow-up on infants lost to diagnostic follow up.				X
4. Hire support staff to assist with tracking and follow up.				X
5. Improve tracking on follow up program for infants at risk for hearing loss.				X
6. Educate primary care providers on genetic factors associated with hearing loss.				X
7. Distribute culturally sensitive educational materials to parents.				X
8. Assure linkage to a medical home.			X	
9.				
10.				

b. Current Activities

Screening at birth, early diagnosis, and prompt referral to early intervention and treatment for hearing loss among newborns is continuing. CT's Newborn Hearing Screening data system is an integral part of the Child's Health Profile. CT has an internet-based reporting system for birth hospitals that links the UNHS data with the Newborn Laboratory Screening program and the Birth Defect Registry data. DPH linked the UNHS database with the Child Health Profile to improve the tracking system report capability.

An ongoing plan is to decrease the number of infants referred from the initial screening but lost to follow up. Program staff attempt to contact the family of infants to ascertain whether there are language, insurance or other barriers that are hindering follow up testing. Program staff notify the infant's PCP by letter on each infant who fails to have follow-up testing from the newborn hearing screening referral.

The Child Health Profile is linked with the electronic vital records system, however problems exist in the current match capability. Program staff are currently involved in revising the method used to match records. Program staff provides technical assistance to hospital staff to support the internet-based reporting system and for any issues surrounding newborn hearing screening.

Program staff send bi-monthly reports to hospitals to track and obtain missing screening results. The PCP is contacted for infants who do not pass the initial screen and have not had follow up testing. Enrollment in early intervention is confirmed for each newborn diagnosed with a hearing loss. The DPH recently hired a full-time UNHS staff person to assist with tracking and follow up.

UNHS program staff meets monthly with the Newborn Hearing Screening Advisory group to discuss issues relevant to infant hearing, early identification and habilitation. The DPH is represented on the Commission on Deaf & Hearing Impaired Advisory Board and meets quarterly. Additional collaboration includes membership in the Directors of Speech and Hearing Programs in State and Welfare Agencies, the state Genomics Advisory Committee, the New England Regional Genetics Group and the New England Regional Hearing Directors group.

c. Plan for the Coming Year

Audiologists, family practitioners, obstetricians and pediatricians will be educated on issues relative to genetics and hearing loss through meetings, grand round presentations and written materials. Program staff will conduct a meeting with the diagnostic testing centers in the Fall of 2005 to review program guidelines, discuss health literacy, genetics in hearing loss and to discuss other advances in newborn screening. UNHS informational materials will be sent to obstetricians to increase their awareness about the program. Educational materials will be developed for families regarding genetic testing and infant hearing loss, and will be disseminated by the audiologist at the time of diagnosis. Educational materials will be developed for infants identified with risk factors for hearing loss, who pass the newborn screening but require ongoing monitoring.

Screening, diagnosis, referral to early intervention and treatment for hearing loss will continue among newborns. Program staff will continue to provide technical assistance to the birth hospitals, health care providers and families regarding newborn hearing screening. Participation on committees related to infant hearing will continue.

The CYSHCN Program is implementing five Regional Medical Home Support Centers in CT. This redesigned CYSHCN system will enhance and improve the linkages between the medical homes, community based resources and referral specialists. UNHS staff will provide education and program information to the Regional Medical Home Support Centers to assure that they and the medical homes in the region are aware of various resources available for infants who are deaf or hard of hearing.

Program staff will conduct another family survey to assess the satisfaction level with the program and to identify areas in need of improvement.

Performance Measure 13: *Percent of children without health insurance.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2000**	**2001**	**2002**	**2003**	**2004**
Annual Performance Objective	5.6	4.8	4.8	4.5	4.4
Annual Indicator	4.3	4.8	4.5	4.7	4.5
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	4.4	4.4	4.3	4.3	4.3

Notes - 2002

Source: US Bureau of the Census, Current Population Survey based on three year rolling averages,2001.

Notes - 2003

Source: US Bureau of the Census, Current Population Survey based on three year rolling averages, 2002.

Notes - 2004

Source: US Bureau of the Census, Current Population Survey based on three year rolling averages, 2003.

a. Last Year's Accomplishments

In keeping with the data source reported in prior years, this year's measure reports on percent uninsured as a three-year average among poor children. Using data from the US Census Bureau, Current Population Survey table "Low Income Uninsured Children by State, 2001, 2002 and 2003" for children under age 19 at or below 200% Poverty, 4.7 % of children in CT are without health insurance (www.census.gov/hhes/hlthins/liuc02.html). This year's percentage exceeds last year's 3-year average of 4.5% of children without health insurance. The targeted goal of 4.5 was not met due to economic issues and state budget constraints. CT compares favorably with data reported in this same table for the United States, namely 7.5%, exceeds the three-year average value for the other five New England states of 2.9%, and continues to rank CT in the top third among U.S. states reported in this table for the smallest percentage of children without health insurance.

The U.S. Census Bureau, Current Population Survey, 2003 Annual Social and Economic Supplement, "Table HI05. Health Insurance Coverage Status and Type of Coverage by State and Age for All People: 2002" (www.ferret.bls.census.gov/macro/032003/health/h05) reports for 2002 that 91.9% of CT's children under 18 were covered by some type of health insurance (private or government). Hence, for the remainder of the children under 18 of all income levels (not just below 200% poverty), 8.1% were uninsured. This compares favorably with data reported in this same table for the United States for 2001, as 11.2% of all U.S. children under 18 were uninsured.

The CT Infoline-211 provided 3 presentations and training to community based providers/agencies and groups to encourage enrollment in CT's SCHIP program, HUSKY. The program provided 24 hours/7 days a week toll-free telephone access to information and referral for maternal and child health issues, including access to insurance programs.

Connecticut's Early Childhood Partners (ECP) made major progress in developing a strategic plan to address the 5 domains of the program which impacts young children's health and learning. The five critical components are: 1) Access to Health Insurance and Medical Homes; 2) Mental health and Social Emotional Development; 3) Early Care and Education/Child Care; 4) Parenting Education; and 5) Family Support.

The 2004 BRFSS telephone survey, sponsored by the CDC, contained state-added questions on health insurance among children. Data for 2004 were collected, but results have not yet been released.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide outreach, screening and referral to sources of health insurance.				X

2. Provide advocacy and liaison to assist families in obtaining health care coverage.		X		
3. Provide education regarding resources to consumers and community based providers.		X		
4. Support the state's information and referral services as a point of access for insurance coverage.			X	
5. Provide follow-up and assistance with insurance application process.		X		
6. Develop capacity with local organization as resources for outreach and enrollment.		X		
7.				
8.				
9.				
10.				

b. Current Activities

HUSKY served as the primary source of publicly funded insurance for the state's uninsured children. As a primary function it provides ongoing outreach, screening and assistance with the eligibility determination process. As part of budget reductions, continuous eligibility was discontinued and coverage for parents or guardians for families up to 150% of the poverty level ended for new families. During 2004, eligibility for families was confusing because of cuts, lawsuits, and injunctions.

Right From The Start, Comadrona, Healthy Start, Family Planning, School Based Health Centers, Community Health Centers, Healthy Choices for Women and Children and WIC screen families for insurance, provided support, information and linkages to health care insurance coverage for children.

Infoline-211, the state's toll free MCH Information and Referral service, provides callers with information regarding HUSKY health insurance. Infoline staff also provide consumers and health care providers with education on HUSKY related issues.

Early Childhood Partners (CT's SECCS program) is developing a strategic plan to address the 3 of the 5 domains of the program that impacts young children's health and learning. implemented the plan which primarily provides coordination of services to the targeted population across public and private agencies statewide.

The Behavioral Risk Factor Surveillance System (BRFSS) telephone survey currently being conducted in 2005 includes a state-added question on health insurance among children as part of a larger group of questions on child health. Data from the survey will be available in 2006.

c. Plan for the Coming Year

To improve the management of state government itself, the Governor is proposing to create a "point of common accountability" for state-level strategic planning, service coordination and integration through the Governor's new Connecticut Early Childhood Investment Advisory Cabinet. The Governor is proposing to invest in and is seeking business, higher education, and philanthropic participation in a CT Early Childhood Research and Policy Council. The Council will activate a research and development arm of the cabinet and guide in key areas of policy relevant early childhood research and evaluation, strategic data management, performance measurement, best practices identification and knowledge dissemination.

Data from the 2004 and 2005 BRFSS will be analyzed and program recommendations

developed to address this measure.

The Perinatal State Health Plan identified as one of its goals the need to improve access to a continuum of health care services for underserved and/or unserved women of child-bearing age. The development of this goal has implications for improved birth outcomes and will assist in identification of insurance for infants as well as their mothers.

Infoline, will continue to provide MCH information and referral services including access to insurance, and will also provide presentations and training to community- based agencies and groups regarding the HUSKY Program.

School Based Health Centers are considering a proposal to study uninsured elementary students to estimate the prevalence of the problem of lack of insurance, identify best practices to increase insurance enrollment, and develop recommendations regarding SBHC's practices to enroll more families in HUSKY.

Performance Measure 14: *Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	40.1	44.1	44.1	43.2	44.3
Annual Indicator	43.4	40.1	43.1	44.2	46.9
Numerator	90390	91893	101043	111992	121521
Denominator	208218	229317	234466	253576	258978
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	47	47	47.1	47.1	47.2

Notes - 2002

Source: CT Dept of Social Services, Form CMS 416 FFY2002

Notes - 2003

CT Dept of Social Services, Form CMS416, FFY2003.

Notes - 2004

CT Dept of Social Services, Form CMS416, FFY2004.

a. Last Year's Accomplishments

The rate for potentially Medicaid eligible children who received a service paid by the Medicaid program increased from 44.2 to 46.9 percent in 2004. The state met its projected goal of 44.3. This increase is considered significant in light of decreased emphasis on outreach and

enrollment by the Department of Social Services (DSS) secondary to the state budget crisis.

A number of Title V and non-Title V programs direct their infrastructure building activities to children and adolescents to improve access and utilization of health care. These are described under current activities.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide eligible Medicaid services at appropriate client sites.	X			
2. Provide screening, identification and referral to insurance programs.		X		
3. Provide care coordination, information & advocacy for families accessing funding programs.		X		
4. Assist providers in maximizing reimbursement for Medicaid eligible services.				X
5. Assist in supporting data systems that capture service utilization activities.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Healthy Choices for Women and Children, Comadrona, Healthy Start, Family Planning, Community Health Centers, School based Health Centers, Children and Youth With Special Health Care Needs and WIC screen clients for health insurance coverage and provide information on how to access programs for which they may be eligible. Dependent upon resources, programs provide advocacy and liaison with the Department of Social Services while educating parents on the Medicaid managed care system. The state's ?safety-net' programs such as Family Planning, School Based Health Centers and Community Health Centers provide Medicaid services to eligible clients.

The Healthcare for Uninsured Kids and Youth (HUSKY), the state's SCHIP program, targets uninsured children to increase enrollment in the program. HUSKY continues its efforts to coordinate services between the DSS, the Children's Health Council and Title V programs to provide outreach and identification of potentially eligible children and adolescents. Through its community-based contacts the program will continue to develop new outreach strategies to reach the uninsured population.

c. Plan for the Coming Year

The Title V and non-Title V programs will continue their efforts as listed above, to assist eligible families with children access and receive Medicaid services.

Performance Measure 15: *The percent of very low birth weight infants among all live births.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	1.4	1.5	1.5	1.5	1.5
Annual Indicator	1.6	1.5	1.6	1.5	
Numerator	690	649	663	637	
Denominator	42660	42708	41687	42564	
Is the Data Provisional or Final?				Provisional	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	1.5	1.4	1.4	1.4	1.4

Notes - 2002

Source: CT Dept of Public Health, Vital Statistics CT2001 Provisional

Notes - 2003

Source: CT Dept of Public Health, Vital Statistics, CY2003 Provisional

Notes - 2004

2004 data not available at this time.

a. Last Year's Accomplishments

Connecticut continues to demonstrate a positive trend in prevention of very low birth infants. The state met its proposed objective of 1.5%. This is attributed to sustained emphasis on the identification of at risk pregnant teens and women through provision of intensive case management, referral and follow up to early and routine prenatal care to pregnant women. These services continued to be embedded in all programs serving Title V eligible pregnant women.

Fetal and Infant Mortality Review provided the infrastructure under which community based teams of health and leadership individuals reviewed 90 perinatal related deaths. Based upon those reviews, very low birth weight was identified as a possible contributing factor for infant mortality.

Healthy Choices for Women and Children provided intensive case management services and linkage of clients with necessary community based services to promote early and consistent prenatal care. Out of 43 births, none were very low birth weight. Of the 2213 infants born to Healthy Start women 33, (or .4%) were identified as low birth weight. Of the 181 infants born to the Right From the Start Program clients, only 3 were determined to be low birth weight.

The WIC Program conducts outreach and enrolls pregnant women eligible for their services. Of those enrolled in the program for at least 6 months of their pregnancy, the rate for very low births was 0.9%.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide outreach, identification and referral of pregnant women to prenatal services.		X		
2. Provide risk assessment and case management to high risk prenatal clients.	X			
3. Provide support and advocacy to assist pregnant women in accessing appropriate services.		X		
4. Provide reproductive health and pregnancy options education.	X			
5. Provide access to food and nutritional support services.		X		
6. Provide culturally competent services to decrease barriers to care.		X		
7. Promote and support systems changes to reduce maternal mortality and morbidity.				X
8.				
9.				
10.				

b. Current Activities

Title V funded programs including Right From the Start, Healthy Start, and Healthy Choices for Women and Children provide support, information and linkages to necessary services to initiate and maintain behaviors compatible with the prevention of very low birth weight infants. Services such as targeted outreach, home visitation and comprehensive case management are used to link prenatal clients with early prenatal care and clients are encouraged to maintain regular care for the duration of their pregnancy. To support women during their pregnancy, programs provide support, advocacy, and referral to services such as WIC and tracks compliance.

Community Health Centers provide risk assessment, care planning and support services to encourage early and routine prenatal care to pregnant women. The program uses extensive outreach, home visitation and onsite site prenatal services (available at 10 of the 11 CHCs) to target women at significant risk for delivering low birth weight babies.

Fetal and Infant Mortality Review (FIMR) programs are funded in 6 communities in the state. This mortality review process uses a confidential and de-identified case approach to provide a comprehensive, multidisciplinary team review of fetal and infant deaths. FIMR uses record abstraction and data obtained from maternal interviews to identify mortality related issues, such as lack of availability of prenatal care, which may contribute to perinatal deaths. Workshops are being conducted to introduce perinatal periods of risk to the FIMR programs in order to complement the FIMR data and better target community interventions.

Family Planning provides pregnancy testing, STD prevention, diagnosis and treatment services, reproductive health education and counseling and assistance in accessing prenatal care services. Clients who are identified as pregnant receive pregnancy options along with a referral for prenatal care and other support services such as WIC and Healthy Start. The program provides pregnancy and sexually transmitted disease testing to identified women at risk of premature delivery and complications due to age, income status or late entry into prenatal care.

WIC provides nutritious foods, nutrition education and related services to pregnant women. With an emphasis on enrolling clients in the first trimester, the program screens clients for enrollment in prenatal health care and actively refers women to services in the community to

ensure that they are enrolled in a timely manner.

SBHCs provides age appropriate reproductive health education, pregnancy testing, STD diagnosis and treatment, counseling and referrals to WIC, Healthy Start and Right From The Start. SBHCs screen and identify teens at risk for or pregnant to assure early diagnosis and referral.

The Perinatal state health plan identified as one of its goals the reduction of perinatal health disparities, particularly preterm/low birth weight births.

c. Plan for the Coming Year

The Right From the Start, Healthy Choices for Women and Children, Community Health Centers, School based Health Centers, Family Planning, FIMR, Healthy Start and WIC will continue their efforts described under the Current Activities Section to promote healthy pregnancies and prevent very low birth weights.

With improved technology in addressing infertility, there has been an increased number of multiple gestation pregnancies that frequently results in preterm delivery of low birth weight infants. The developing Perinatal State Health Plan will provide information as to the extent of the problem and provide recommendations for to the DPH in addressing this health issue. Recommendations from the perinatal health advisory committee that address low birth weight and very low birth weight will be reviewed and implemented as part of the state perinatal health plan.

Performance Measure 16: *The rate (per 100,000) of suicide deaths among youths aged 15 through 19.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	4.5	4.5	9.2	5.6	5.6
Annual Indicator	7.8	9.7	5.6	2.6	2.5
Numerator	17	21	13	6	
Denominator	216627	216627	230667	234895	
Is the Data Provisional or Final?				Provisional	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	2.5	2.4	2.4	2.4	2.3

Notes - 2002

Source: CT Dept of Public Health, Vital Statistics CY2001 Provisional

Notes - 2003

Source: CT Dept of Public Health, Vital Statistics CY2003 Provisional

Notes - 2004

Source: CT Dept of Public Health, Vital Statistics CY2004 data are not expected to be available until a year from now. The 2.5 rate represents what we would like to change the 2004 annual performance objective goal to read based on our most recent experience i.e. 2003 data. This field is "locked" by the TVIS form's programming at what we entered last year based on 2002 experience.

a. Last Year's Accomplishments

Suicide rates among Connecticut youth aged 15 through 19 are unstable because of the relatively small number of deaths. In 2004, the suicide rate was 2.5 in 100,000, which decreased from the 2003 rate of 2.6 in 100,000 (CT Vital Statistics). In Connecticut, 16.2% of high school youth completing the Youth Risk Behavior Survey (YRBS) said that they seriously considered attempting suicide (YRBS 2003).

Both Title V and non-Title V programs provided services to adolescents with the goals of improving mental health, facilitating appropriate referral and reducing suicidal thoughts and actions among high school youth.

School Based Health Centers provided comprehensive mental health services to enrolled students at all sites. SBHCs have policies and procedures in place that address Center-specific protocols for handling youth with suicidal thoughts and attempts. During the 2003-2004 school year, mental health--related care encompassed 33.5% (29,750) of all visits to SBHCs. They continue to assure these mental health services through direct provision of care via on-site clinicians such as social workers, psychiatrists and psychologists and through referrals to community agencies such as local hospitals, child guidance centers and mental health centers. They will continue to provide these services in the coming year.

SBHCs also conducted health education sessions. Topics included violence prevention, stress, self-esteem, healthy relationships and grief/bereavement.

Infoline, Connecticut's information and referral service, provided 22 suicide prevention presentations and training to providers, agencies, community groups and students in the state. Community Health Centers provided mental health services through screening, assessment, direct care and/or referrals.

Healthy Choices for Women and Children (HCWC) provided comprehensive assessment of clients (55 women), including the need for mental health services. This program continued to identify and refer clients who are at risk for suicide to appropriate resources.

Right From the Start (RFTS) provided a comprehensive assessment of clients (347 teens), including the need for mental health services. Referrals were made as necessary.

There were also a number of non-Title V funded activities. The Injury Prevention Program funded a contractor to provide suicide prevention training focused on adults and providers on college and university campuses and in the community. The Contractor provided six sessions of training to a total of 48 adults. The Injury Prevention Program also funded violence prevention programs that focus on middle and high school aged youth. Most programs are community-based and integrate suicide prevention into ongoing violence prevention activities and training.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide suicide prevention training to students.				X
2. Provide suicide prevention training to providers and other adults.			X	X
3. Provide technical assistance and guidance for MCH programs.				X
4. Provide anticipatory guidance and risk assessments in Title V funded programs, especially School Based Health Centers.	X	X	X	
5. Provide mental health services through assessment, direct care and/or referrals in School Based Health Center, Community Health Centers and other MCH programs.	X	X		X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Community Health Centers provide mental health services through assessment, direct care and/or referrals. They continue to assure these mental health services through direct provision via onsite clinicians such as social workers, psychiatrists and psychologists and through referrals to community agencies such as local hospitals, child guidance centers and mental health centers. The Community Health Centers (CHC) are working closely with the Child Guidance Centers across CT, and some of the Child Guidance Centers are operated by CHCs.

School Based Health Centers continue to provide anticipatory guidance and mental health risk assessments at all locations. Other mental health services include crisis intervention, individual, family, and group counseling and referral and follow-up for specialty care. All SBHCs offer services directed at high-risk populations, such as youth with suicidal thoughts/attempts.

Through the use of a specially designed Mid-year report, SBHC sites reported on the following mental health related issues: successes in service delivery, trends, gaps/barriers, and potential solutions. Data is analyzed and used in planning future initiatives.

Thirty-five individual SBHC mental health clinicians received Master Therapist training funded by DPH. Clinicians may opt to attend workshops covering diverse mental health issues. A total of 52 workshops were funded this year. A total of 26 therapists attended the workshop on bipolar disorder in adolescents.

Healthy Choices for Women and Children provides comprehensive assessment of clients, including the need for mental health services. Referrals are initiated as necessary. This program continues to identify and refer clients who are at risk for suicide to appropriate resources.

Right From The Start continues to provide comprehensive assessment of clients, including the need for mental health services with referral as necessary.

There were also non-Title V funded activities. The Intentional Injury Prevention Program funds United Way of CT/Infoline to provide suicide prevention training for students, providers and other adults in college and university settings and the community. The Program will continue to provide guidance related to suicide prevention and other intentional injury issues to other DPH

program staff.

c. Plan for the Coming Year

The program activities presented in the Current Activities section will be continued into FY06 with the continued goals of improving mental health, facilitating appropriate referral and reducing suicidal thoughts and actions among adolescents.

School Based Health Centers will continue to provide anticipatory guidance, risk assessments and mental health therapy at all locations. Efforts will continue to enhance data collection tools related to mental health service delivery at SBHCs. Technical assistance for staff will also continue. A major initiative is planned to enhance the skills of mental health practitioners through the Connecticut Primary Care Services Resource Coordination and Development (PCO) grant. Three distinct activities in the PCO grant are designed to address NPM 16: (1) At least 50 SBHC staff will receive technical assistance to enhance the efficacy and efficiency of culturally competent mental health services to SBHC staff. A SBHC mental health workgroup will identify a uniform data collection system among all SBHC sites to collect and aggregate information on hi-risk youth in need of mental health services; (2) Two regional workshops will be conducted to introduce IPT-A (interpersonal Therapy for Adolescents) model and Hamilton Rating Scale (Depression Screening Tool) to SBHC clinicians; (3) Ten mental health clinicians at SBHCs will be selected to be trained on the use of the screening tools. Forty SBHC enrollees will receive counseling sessions based upon the IPT-A model for a series of twelve sessions.

RFTS, HCWC and CHCs will provide services described under current activities to reduce suicide deaths for youth 15-19 years and work more closely with the injury prevention program. The Community Health Centers (CHC) will continue to work closely with the Child Guidance Centers across CT, and some of the Child Guidance Centers are operated by CHCs.

Performance Measure 17: *Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	86	86.2	83.1	87.5	87.5
Annual Indicator	82.3	83.1	87.5	87.4	
Numerator	568	539	580	557	
Denominator	690	649	663	637	
Is the Data Provisional or Final?				Provisional	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance	87.5	87.5	87.6	87.6	87.6

Objective					

Notes - 2002

Source: CT Dept of Public Health, Vital Statistics CY2001 Provisional

Notes - 2003

Source: CT Dept of Public Health, Vital Statistics CY2003 Provisional.
Eleven of CT's acute hospitals with self-declared NICU's were included in this survey.

Notes - 2004

2004 data not available now, anticipated a year from now.

a. Last Year's Accomplishments

In 2004, 87.4 percent of births of very low birth weight infants were delivered at facilities for high-risk deliveries and neonates. This percentage was a slight decrease from 87.5 percent in 2003. Connecticut did not meet its proposed objective of 87.5 percent. Title V perinatal programs, such as Right From the Start, Healthy Choices for Women and Children, and Healthy Start provided screening for early identification and referral for teens and women identified as high risk pregnancies.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide outreach, identification and referral of high risk pregnant teens.		X		
2. Provide intensive case management and supports to promote positive pregnancy outcomes	X			
3. Provide culturally competent and linguistically appropriate care to high-risk populations.		X		
4. Collaborate with tertiary care centers that provide specialized delivery and neonatal care.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

CT has 29 birthing hospitals statewide and one birthing center located in Danbury, CT, contiguous to the New York border. There are 11 "self-defined" Level III NICU's in CT.

DPH organized a Perinatal Advisory Committee to conduct a statewide needs assessment, which developed the first Perinatal State Health Plan. The committee was composed of representatives from the: Connecticut Hospital Association, Connecticut Women's Consortium, March of Dimes Federal New Haven Healthy Start, tertiary care facilities, local health departments, State Medical Society, Planned Parenthood, Connecticut Primary Care Association, private practice clinicians, American Academy of Pediatrics and state agencies such as Departments of Children and Families, Mental Health and Addiction Services, Social Services and the Permanent Commission on the Status of Women. One of the recommendations in the plan identifies the need to reduce pregnancy and birth related risk

factors by facilitating maternal transfers to tertiary perinatal/neonatal centers for high risk antepartum, intrapartum and postpartum care.

Title V funded programs including Comadrona, Healthy Start, Right From the Start and Healthy Choices for Women and Children provide outreach, screening, intensive case management and referral for high-risk pregnant women to specialists and tertiary care centers as indicated. Through their case management approach, women identified as at-risk are referred for appropriate evaluation. Programs, such as Comadrona provides targeted outreach, risk assessment and case management services to pregnant women who, by virtue of cultural and linguistic barriers, have difficulty in obtaining needed care and are referred to culturally appropriate health and related social services.

c. Plan for the Coming Year

Comadrona, Right from the Start, Healthy Start, Family Planning, Healthy Choices for Women and Children and Community Health Centers will assess and refer high risk pregnant women to facilities for high-risk deliveries and neonates.

The Perinatal Advisory Committee will be reconvened and recommendations from the Perinatal State Health Plan that impact this measure will be reviewed and implemented as resources are available.

Performance Measure 18: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	89.1	89.1	88.9	88.8	88.9
Annual Indicator	85.5	88.8	88.5	88.8	
Numerator	36773	36823	36358	37454	
Denominator	43030	41478	41080	42176	
Is the Data Provisional or Final?				Provisional	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	88.9	89	89.1	89.2	89.2

Notes - 2002

Source: CT Dept of Public Health, Vital Statistics CY2001 Provisional

Notes - 2003

Source: CT Dept of Public Health, Vital Statistics CY2003 Provisional

Notes - 2004

CY 2004 Vital Statistics data are expected to become available one year from now.

a. Last Year's Accomplishments

In CT in 2003, 88.8% of infants were born to woman who began to receive prenatal care in the first trimester, which was a slight increase from 88.5% in 2002. Connecticut met its projected goal of 88.8%. Title V programs provided outreach and identification of pregnant women to promote early entry into prenatal care.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide outreach and case management to identify and enroll clients in early prenatal care.		X		
2. Provide culturally & linguistically appropriate services to decrease barriers to prenatal care services.		X		
3. Provide outreach to targeted populations (i.e. pregnant substance users).	X			
4. Provide support, information and advocacy to pregnant teens.		X		
5. Continue to analyze PRATS Survey data.			X	
6. Provide pregnancy testing, reproductive health education, counseling & linkage to healthcare providers	X			
7. Support community based fetal and infant mortality review processes.				X
8. Promote early enrollment into prenatal care as a linkage from programs such as WIC.			X	
9. Provide/promote comprehensive services to encourage women of reproductive age to enter prenatal care early		X		
10.				

b. Current Activities

Comadrona, Healthy Start, Healthy Choices for Women and Children, Right From The Start, Family Planning, School Based Health Centers, Community Health Centers and WIC use its community-based networks to identify and refer women to prenatal care providing advocacy and a culturally sensitive approach in promoting the benefits of early and appropriate prenatal care.

Fetal and Infant Mortality Review is comprised of community-based teams of health and leadership individuals who reviewed fetal and infant deaths. FIMR uses a confidential record abstraction, and home visits to identify mortality related issues including late entry into prenatal care.

The Perinatal State Heal Plan identified as one of its goals to improve access to a continuum of health care services for underserved and/or unserved women of childbearing age. This goal will be implement in the plan for next year's activities

c. Plan for the Coming Year

Comadrona, Right from the Start, WIC, Healthy Start, Fetal and Infant Mortality Review, Family Planning, School Based Health Centers, Healthy Choices for Women and Children and Community Health Centers will continue their efforts as described in the Current Activities section by encouraging early entrance into prenatal care.

The Perinatal State Health Plan's goal to improve access to a continuum of health care services for underserved and/or unserved women of childbearing age will be implemented depending upon available resources.

The newly developed state added performance measure will allow CT to more effectively address the racial and ethnic disparities that were identified as part of the five-year needs assessment which impacts this measure.

D. STATE PERFORMANCE MEASURES

State Performance Measure 1: *The percentage of CSHCN clients enrolled in the State CSHCN program that have a written health care service plan.(was numbered 25 in a prior year)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	85%	95%	95%	95	96
Annual Indicator	92.7	95.5	92.6	95.7	91.9
Numerator	644	513	647	512	1130
Denominator	695	537	699	535	1229
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	93.5	95	96.5	98	98

Notes - 2002

Source: CSHCN Centers. Note: those not enrolled were very new to the program. If this measure were assessed for those who were known to the program 3 months or longer, we expect it would approximate 100%.

Notes - 2003

19. State Performance Measure #1
Source: CSHCN Centers. If this measure were assessed for those who were known to the program 3 months or longer, we expect it would be substantially higher.

Notes - 2004

19. State Performance Measure #1
Source: CSHCN Centers. If this measure were assessed for those who were known to the program 3 months or longer, we expect it would be substantially higher.

a. Last Year's Accomplishments

In 2004, 91.9% of the children enrolled in the Children and Youth with Special Health Care

Needs (CYSHCN) Program had a written care service plan, which is below the objective of 96%; this objective was not met. The staff at the CYSHCN Centers are contractually responsible for their own internal ongoing medical record audits to ensure that written care service plans are developed for each client, in concert with the family so that plans are comprehensive and collaborative. Children and Youth with Special Health Care Needs (CYSHCN) receive services from a multitude of subspecialty providers. A written care service plan helps maximize the delivery of health care services by coordinating and assuring the provision of necessary and quality services. One of the goals of the CYSHCN Program is to assure that CYSHCN receive coordinated and comprehensive primary care, specialty care, and community-based resources, which are measured and monitored.

The CYSHCN Program continued to coordinate and collaborate care for children with special health care needs and to measure and monitor coordinated care and services provided in a written care service plan. A written care service plan for children enrolled in the Title V CYSHCN program remained a contractual requirement for the CYSHCN Centers. There was a summer 2004 seminar introducing new medical homes to the concept and practice principles.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Redesign the Statewide Care Coordination Program including standardization of the health care service plan.				X
2. Ongoing DPH Quality Assurance monitoring for the presence and quality of health care service plans.				X
3. Quarterly review of the CSHCN Center?s quality assurance monitoring of the health care service plans.				X
4. Incorporate Family Centered Portable Health Service Plan in development of Medical Home Collaborative Project				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The 5 Regional Medical Home Support Centers, a statewide system designed to enhance care coordination activities, is being implemented. The new system is in response DPH's needs assessment of gaps and barriers to services for CYSHCN and their caregivers. The redesigned system will enhance care coordination by increasing the numbers of CYSHCN by care providers using the Screener Tool. Through the use of the Complexity Index Tool, primary care providers will identify CYSHCN and families/caregivers in need of a level of care coordination that the provider's practice may not be adequately skilled to achieve and thus make referral for assistance to the RMHSCs.

The MHLC, the RMHSCs and Title V staff are actively engaged with DocSite in the planning and implementation of a web-based quality improvement database management system which will be linked to the State's Child Health Profile database. The DocSite system will enable the Medical Homes and RMHSCs to review and capture data and update care service plan

activities with the CYSHCN and their families/caregiver at the point of care. DocSite has been chosen as the candidate system for this function because of their partnership with the National Initiative for Children's Healthcare Quality (NICHQ) Medical Home Learning Collaborative. CT was one of eleven states that participated in this nationwide collaborative and our pilot medical home sites are currently working with the DocSite system.

DPH, through its partnership with the Child Health & Development Institute, contracted with the UConn Area Health Education Centers to develop and implement a Medical Home Academy (MHA) for pediatric health care providers and families. The curriculum of the MHA will help ensure that providers are knowledgeable and skilled at providing children and youth in the State of CT and their caregiver with care service plans that are family-centered, community-based, comprehensive and coordinated.

The MHLC, in conjunction with the Title V team continued their work to develop and implement a portable plan of care for CYSHCN and their caregivers. The MHLC has chosen the Emergency Information Form (EIF) endorsed by The American College of Emergency Physicians and the AAP as the suggested template for the portable plan of care. This important document will assure prompt and appropriate care for CYSHCN when they present to health care professionals. The EIF is a tool to transfer critical information and ensure that a child's complicated medical history is concisely summarized and available when it is needed.

The EIF is incorporated into DocSite as an element of the service care plan. The EIF is a document that families can use to navigate the health care system and assure that they receive appropriate care in an appropriate environment. RMHSC staff will receive training and technical assistance on the use of DocSite to facilitate the design and delivery of care service plans in partnership with CYSHCN and their families/caregivers.

c. Plan for the Coming Year

Children and youth will be triaged by Primary Care Providers based on their utilization of the CYSHCN Screening Tool and the CYSHCN Complexity Index Tool which are elements of the DocSite System and referring the CYSHCN to a Regional Medical Home Support Center for care coordination activities. DocSite Visit Planner forms will be completed for every contact with the child and family. This Visit Planner form will provide the foundation for the development of the written care service plan. RMHSC staff will receive training and technical assistance on the use of DocSite to facilitate written care service plans.

State Performance Measure 2: *The degree to which the Connecticut State Department of Public Health improves mental health screening, assessment, referral and linkages to services and supports in Title V funded programs.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective		2	5	9	10
Annual Indicator	0	2	5	9	10

Numerator	0	2	5	9	10
Denominator	12	12	12	12	12
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	12	12	12	12	12

Notes - 2002

This measure started in FY2000, so data entered in FY 1998 and 1999 should be ignored. Before FY2000 there was a state performance measure dealing with this topic, but with a different/inferior methodology which was dropped in favor of the current method/measure which was negotiated with and approved by MCHB staff.
FY2002 accomplishments towards achieving this goal included 3 of the 12 criteria :
Assessment of current mental health-related practices (including direct services, education and data collection) within:
1)School-Based Health Centers,
2)Pediatric Primary Care Centers located within Community Health Centers, and
3)the CSHCN program.

Notes - 2003

State Performance Measure #2
FY2003 accomplishments towards achieving this goal included 4 more of the 12 criteria now totalling 9 cumulative steps completed thus far. New steps accomplished are:
Implement data collection & evaluation methods within the
1)SBHC,
2)CSHCN,
3)Right From the Start Program, and
4)Pediatric Primary Care Clinics located within CHC's
to determine the extent to which appropriate mental hlth screening, assessment, referral & linkages are in place.

Notes - 2004

State Performance Measure #2
FY2004 accomplishments towards achieving this goal included 1 more of the 12 criteria now totalling 10 cumulative steps completed thus far. The new step accomplished was: Provide training and technical assistance to Tile V funded programs to implement and/or enhance appropriate mental health screening, assessment, referral and linkages based upon identified needs.

a. Last Year's Accomplishments

In FY2004, 10 of the 12 objectives were met, meeting the projected goal for that year. Data collection activities continued to assure increased screening for mental health services and supports in Title V funded programs. Training and technical assistance was provided to Title V funded programs to implement and/or enhance appropriate mental health screening, assessment, referral, and linkages based upon identified needs.

The CHCs provided 782,216 visits to 188,908 clients. During this time there were 53,651 mental health visits and 40,132 visits provided to CHC clients through the comprehensive health services model. The CHCs have implemented integrated primary care and mental health care services.

DPH staff informed the CHC Executive Directors of a competitive federal grant funded under

the Consolidation Act of 1996 to increase services in Mental Health and Substance Abuse. DPH staff provided CHCs with information from Screening for Mental Health, Inc., a nonprofit organization developed to coordinate nationwide mental health screening programs, and to ensure cooperation, professionalism and accountability in mental health screenings.

DPH cosponsored the "Adolescent Health: What You Need to Know" conference with the Norwalk SBHCs, CHCs, and Health Department. This statewide conference attracted participants who are health, social services, education and outreach providers of services to adolescents.

A family survey administered by the CYSHCN Centers provided information on access to mental health services. The Centers provided information on 74 surveys that identified almost 17% of children and adolescents enrolled at the Centers accessed mental health services, over 42% needed but did not receive mental health services.

Staff at DPH provided mental health information to CYSHCN Centers including the National Mental Health Information Center Publications Catalog from SAMHSA. DPH staff also shared information on updates to CT's KidCare System.

SBHCs activities included risk assessment, screening, education, counseling and referrals. SBHCs were required to submit the type, number, and quality of activities to DPH through reporting tools. Review of SBHC reports allows DPH staff to monitor current levels of service and identify where significant gaps and barriers still remain.

In this period, 17 of 18 SBHC sites utilized a formal mental health assessment tool such as the Guidelines for Adolescent Prevention Services. This year unduplicated mental health visits at SBHCs totaled 31,088, an increase of 11.75% since last year. All 18 sites now document a disposition code for all student visits to the SBHC utilizing the Clinical Fusion data tracking system.

All RFTS sites provided a comprehensive risk assessment and screening including mental health needs. 10.4% were identified and referred to appropriate providers, and tracked to determine if they obtained those services. 75% actually received assessment services.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide screening, assessment, referral, and linkage for mental health needs.		X		
2. Provide mental health treatment services.	X			
3. Collect data related to mental health screening, referral, assessment and linkage.		X		
4. Provide training and technical assistance supporting best practice for mental health, screening, assessment, referral, and linkage.		X		
5. Work with statewide groups to enhance access to mental health screening, assessment, referral, linkage, and access to treatment services. (State Adolescent Health Strategic Plan, Early Childhood Partners, Mental Health Cabinet)				X
6.				
7.				

8.				
9.				
10.				

b. Current Activities

DPH program staff will provide a range of resources relating to violence against women and family violence with an emphasis on culturally competent programs. CHC's medical directors were notified of the public forum addressing "Effects of Domestic Violence in the Latino Community in CT." The CHC medical directors were also informed of the free web based brochures printed in eight languages for immigrant and refugee women produced by the Family Violence Prevention Fund.

DPH program staff will be meeting with the Clinical Issues Committee, a group of Medical Directors and Clinical Coordinators of CHC's statewide, to discuss the resource materials and technical assistance available through the "Bright Futures in Practice for Mental Health : Practice Guide and Tool Kit" a publication of HRSA, MCHB, and the national Center for Education in Maternal and Child Health at Georgetown University.

DPH has partnered with the CT Lifespan Respite Coalition, Inc. to produce the "Get Creative About Respite" manual, which helped families to identify creative respite solutions. Please see Section E State Agency Coordination for additional information.

Funding was available from through the SBHC training funds for staff to access training through the Master's Therapist Series, attended by 35 SBHC staff. This year there was 52 workshops available an increase of almost 21% from last year. A conference is planned for SBHC mental health clinicians, coordinators and billing personnel to enhance mental health coding procedures and documentation. SBHC Midyear reports are being analyzed to identify mental health trends, successes in service delivery, gaps, barriers, and potential solution. Mental health is identified as a priority area in the State Adolescent Health Strategic Plan.

Funds from the Bureau of Primary Care Office will support training a cadre of SBHC mental health clinicians in the use of a best practice model for screening and intervening with depression in youth.

All RFTS sites will continue to screen clients for mental health issues, refer and track those to determine if they received the needed assessments.

The FHS received funding to launch Early Childhood Partners (ECP) to assure that all children are healthy and ready to learn at age five, highlighted areas include mental and developmental health.

The Governor's office created a Mental Health Cabinet to develop recommendations for specific actions to improve the availability and effectiveness of mental health care in CT based upon the findings of the Blue Ribbon Commission Report of 2000.

DPH, in collaboration with Pfizer Pharmaceuticals, convened a workgroup to address perinatal depression screening, and will utilize PCO funding to address the integration of mental health and primary care services using CHCs as a pilot.

c. Plan for the Coming Year

Community Health Centers will continue to provide mental health screening, assessment, referral, linkage, and treatment within constraints of on going fiscal concerns. CHC's are practicing integrated primary care in all sites through various locations. PCO funding will allow

for a Perinatal depression screening pilot project at 2 CHC's. The Perinatal Depression Workgroup will be reconvened on a monthly basis to develop and implement the plan for the pilot project.

DPH was awarded a HRSA grant to conduct a public awareness campaign for perinatal depression. This grant is a collaborative partnership with the DMHAS, United Way of CT/Infoline, Yale University and the New Haven Health Department. Focus groups will be conducted to gather information, which will shape the public awareness campaign. Training will be provided statewide to health care providers regarding screening for perinatal depression.

The SBHC programs will continue to provide comprehensive mental health-related services to students. The cadre of Clinicians will be trained in the best practice model for screening and intervention for depression in youth. Continue to promote the goals of the SBHC workgroup as they relate to mental health services (improve data management system, facilitate a centralized billing system and maximize SBHC revenue). Begin to implement mental health strategies as outlined in the Adolescent Health Strategic Plan.

RFTS will continue to provide support, information and screening of pregnant and parenting teens for mental health issues and referral to assessment and treatment services as needed. Please see the website http://www.dph.state.ct.us/BCH/Family%20Health/cyshcn/cyshcn-medical%20home%20site.htm for information on how CT Medical Home system of care will continue to address this performance measure.

State Performance Measure 3: *Pediatric Mortality due to injury. (The rate of deaths to children aged 1-19 caused by unintentional and intentional injury). (Was #22 in a prior year)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	11.2	10.9	11.5	11.7	11.5
Annual Indicator	11.2	11.9	11.9	9.9	9.9
Numerator	99	105	109	92	
Denominator	882762	882629	916836	927004	
Is the Data Provisional or Final?				Provisional	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	9.8	9.8	9.7	9.7	9.6

Notes - 2002

Source: CT Dept of Public Health, Vital Statistics, provisional CY2001.

Notes - 2003

Source: CT Dept of Public Health, Vital Statistics, Provisional CY2003

Notes - 2004

Source: CT Dept of Public Health, Vital Statistics, Provisional CY2003 is the latest data available. The form would not allow us to change the 2004 Annual Performance Objective goal from 11.5 to 9.9 to reflect our most recent experience.

a. Last Year's Accomplishments

Injuries (intentional and unintentional) continue to be the leading cause of death for Connecticut residents between the ages of 1 and 19 years, accounting for 55% of all deaths for this age group. In 2003 there were 92 deaths among an estimated 927,004 children for a rate of 9.9 per 100,000. This is decrease from the 2001 and 2002 rates of 11.2 and 11.9 respectively. The annual performance measure target was met. Injuries were also responsible for 2,645 inpatient hospitalizations and over 119,000 Emergency Department visits (1999, CT hospital discharge data set, CT Hospital Association). The leading cause of mortality for children and youth aged 1 to 19 years is addressed in a number of ways. Several Title V funded and non Title V programs address injury prevention for infants, children and adolescents. More details on these programs are presented in the Current Activities Section, some highlights are presented here.

The Injury Prevention Program (IPP) provided technical assistance and program monitoring to local health departments conducting unintentional injury and youth violence/suicide prevention programs.

Technical assistance and resource materials on a range of injury prevention issues have been provided to other DPH programs, MCH providers and community groups. The IPP is a member of CT SAFE KIDS Coalition and have collaborated on activities geared to prevent childhood injuries. The IPP facilitated the CT Young Worker Safety Team, which is a collaborative effort with local, state and federal members to raise awareness and provide education and training on adolescent worker safety. Members of this group have sponsored of conducted over 75 workshops and presentations during the past 4 years.

Community Health Centers, as EPSDT providers, provided children and/or their caregivers age appropriate risk assessments, anticipatory guidance and injury prevention information related to motor vehicle safety.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide risk screening identification, education and linkages and anticipatory guidance.	X			
2. Collaborate with statewide advocates to address injury-related mortality.			X	X
3. Enhance data collection methods and utilize injury-related data to guide planning for state and community based programs and policy development.			X	X
4. Provide funding and technical assistance to contractors providing injury prevention programs and activities for children.		X	X	X
5. Monitor & provide guidance for policy development that addresses injury-related mortality among children and youth.			X	X
6. Participate in statewide and regional coalitions and collaborations that provide and facilitate public and professional education, policy change				

and system enhancements that improve injury prevention services and programs for children and youth.		X	X	X
7.				
8.				
9.				
10.				

b. Current Activities

The IPP funded violence prevention programs focus on middle and high school aged youth. Most programs are located on community based settings and provide services after school, weekends and during school vacations. Two SBHCs funded through their local health departments also conduct violence prevention programs. Programs employ a variety of strategies and methods to increase participant knowledge and behaviors related to non-violent resolution of conflict.

Unintentional injury prevention activities funded though the PHHSBG allocation to local health departments focus on motor vehicle injuries, childhood injuries in the home setting, and falls among older adults. The IPP continues to collaborate with CT SAFE KIDS and other partners on injury prevention. Members of the CT Young Worker Safety Team facilitated by DPH presented on young worker safety issues at 15 meetings, conferences or classes. The program provided support for legislation addressing teen drivers, safety belts, motorcycle helmets and booster seats during the 2005 legislative session.

The Family Health Section received continuation funding from the National Highway Traffic Safety Administration (NHTSA) for CT's Crash Outcome Data Evaluation System (CODES). Funding will allow for purchase of hospital and Emergency Department (ED) data until 2009. The CODES project links police crash reports with death, hospital, and ED Data to provide a more comprehensive picture of motor vehicle crashes, injuries and deaths. This enhanced data set will be useful in planning and evaluating programs and policies aimed at reducing motor vehicle injuries in the 1 to 19 year age group.

Comadrona, Healthy Choices for Women and Children and RFTS provide risk screening, identification, education and linkages to resources for pregnant/postpartum teens and women to prevent/reduce incidents of injury to their children.

CHCs provide risk assessments, anticipatory guidance and health education materials on an individual basis to children and their caregivers. Health promotion materials about Never Shake A Baby (to prevent shaken child syndrome) and Baby Back to Sleep (to prevent SIDS) were distributed to CHCs on site visits. During the current year the CHCs were invited to participate in the CT SAFE KIDS conference on September 16, 2004. English and Spanish posters on Choking Prevention and Childproofing reminders were distributed electronically to CHCs for use in waiting rooms. CHCs also disseminate information through health fairs, school education programs and other community/neighborhood events.

SBHC provide classroom-based workshops on issues such as "stranger danger", bicycle safety and child safety education for teen mothers. SBHCs practitioners are encouraged to increase the use of GAPS to identify at-risk children and provide interventions directed at reducing deaths due to injuries and will improve their reporting system to track injuries.

c. Plan for the Coming Year

The Right From the Start, Healthy Choices for Women and Children and Community Health Center programs will continue to enhance collaboration with Injury Prevention Staff to reduce the death rate of children ages 1 to 19 years. Injury prevention activities will continue to be part

of SBHCs comprehensive services.

The Injury Prevention Program will provide technical assistance and resources and work closely with the other FHS programs to integrate injury prevention into Title V and other programs serving children and youth. The Program will also strengthen collaborations with other DPH programs outside the Section and other agencies, organizations, and coalitions addressing injury prevention.

Specific activities addressing suicide among 15-19 year olds are listed under NPM #16 and addressing motor vehicle crash injuries among birth to 14 year olds are included under NPM #10.

The IPP will work with other organizations and agencies concerned with motor vehicle injury to utilize CODES data in program and policy development especially for the 15-19 year old population. Motor vehicle crashes are the leading cause of death for 15-19 year olds, but are not addressed under National Performance Measure 10.

State Performance Measure 4: *The degree to which Title V programs target services to racial and/or ethnic groups with disparities in pregnancy outcomes.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective		1	4	7	8
Annual Indicator	0	1	4	6	8
Numerator	0	1	4	6	8
Denominator	12	12	12	12	12
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	8	8	9	10	11

Notes - 2002

2002 data represent DPH staff and colleagues' accomplishing three of the 12 criteria that comprise this measure:
1) Establish an interdivisional workgroup within DPH to address racial and ethnic disparities related to adverse pregnancy outcomes(i.e. low birth weight , preterm birth, infant mortality and maternal mortality) among clients of Title V programs.
2) Document the demographic information available from Title V programs to determine the racial and ethnic characteristics of the clients served. and
3) Evaluate demographic information from each Title V program to determine whether the clients served by the program are representative of those at highest risk of adverse pregnancy outcomes among the population served by the program.

Notes - 2003

22. State Performance Measure #4
With 2 new steps completed in 2003, DPH staff & colleagues have now accomplished 6 of the 12 criteria that comprise this measure. The 2 Steps accomplished were:
1) Select Title V programs/locations for expanded effort to reduce racial/ethnic disparities in adverse pregnancy outcomes; and
2) Develop & implement outreach programs to expand enrollment of high risk groups in selected Title V program/locations.

Notes - 2004

22. State Performance Measure #4
Two (2) new steps were completed in 2004 making total of 8 of the 12 criteria to date. The newly accomplished criteria were: #5 - Document culturally competent and developmentally appropriate strategies to address adverse pregnancy outcomes; and #10 - Establish an interdisciplinary workgroup (including consumers representing the target high risk groups) to mount a coordinated statewide perinatal initiative.

a. Last Year's Accomplishments

In 2004, CT DPH was able to meet 8 of the 12 indicators for this performance measure. The Department of Public Health met our goal of 8. Much of the Department's progress on this performance measure relates to activities of the Perinatal Advisory Committee organized to develop the Perinatal State Health Plan.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Establish a Perinatal Advisory Committee				X
2. Tracking of perinatal outcomes by race/ethnicity and community.			X	
3. Monitor Title V programs for proportion of racial/ethnic clients served.			X	
4. Implement the Cultural Competence Assessment Tool to Title V programs.				X
5. Develop a Perinatal State Health Plan				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

A cultural competency self-assessment tool developed by the FHS for contractors receiving Title V funding was mandated as part of the contractual requirements. The tool serves to provide those contractors with a framework to assess the degree to which and manner in which they address the cultural and linguistic needs of the populations they serve. As part of the site visit process Title V community based contractors are provided with technical assistance to develop mechanisms for improving their performance in meeting client needs.

The Perinatal State Health Plan was developed. One of the identified goals addressed in the plan is the reduction of perinatal health disparities, particularly preterm/low birth weight births and infant and fetal mortality between and among racial and ethnic groups. A total of five

objectives with nine related strategies were identified to meet this goal.

Right From the Start, Healthy Choices for Women and Children, Healthy Start, Community Health Centers and Comadrona Programs continue their emphasis on reduction of racial/ethnic disparities by providing culturally sensitive and appropriate services.

A state needs assessment for bereavement services for fetal and infant mortality (including SIDS) is currently being conducted. The assessment will identify resources, supports and barriers to accessing services while addressing racial and ethnic disparities. The consultant will develop or identify an existing evidence-based public awareness campaign to target populations identified in the assessment with high rates of fetal and infant mortality.

c. Plan for the Coming Year

The DPH will implement the objectives and strategies identified in the state Perinatal Health Plan that relate to the goal of reducing perinatal health disparities

The Right from the Start, Comadrona, Community Health Centers, Healthy Start, Healthy Choices for Women and Children and Fetal and Infant Mortality Review Programs will continue their efforts as described in the Current Activities Section.

Recommendation from the State Bereavement Assessment will be implemented and a public awareness campaign, to reduce infant mortality in vulnerable populations will be conducted.

Staff will meet with DPH's Office of Multicultural Health to strengthen and integrate the Department's efforts in such public health priority areas as health disparities.

A state performance measure has been developed to address racial and ethnic disparities regarding early entry into prenatal care for pregnant teens.

State Performance Measure 5: *The degree to which the Connecticut Department of Public Health has developed and implemented a Statewide Genetics Plan.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective		3	6	8	7
Annual Indicator	0	4	4	6	10
Numerator	0	4	4	6	10
Denominator	10	10	10	10	10
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual					

Performance Objective	10	10	10	10	10

Notes - 2002

In 2002-3 there was an organizational shift in responsibility for this program resulting in no new criteria accomplished for this year.

Notes - 2003

23. State Performance Measure #5
In 2003, 2 new criteria/steps were completed totalling 6 of the 10 criteria now accomplished. The 2 new steps accomplished were:
DPH's Family Health Div. will
1) develop partnerships with consumer groups and other services (CT PKU Planning Group, March of Dimes, CT Dept of Education, CT Local Health, & Dept of Insurance) to identify & address special needs of children with genetic & metabolic disorders; and
2) identify stakeholders & expand the Genetic Advisory Committee (GAC) to provide a forum for the exchange of genetic information among consumers, healthcare professionals, policymakers, & educators.

Notes - 2004

23. State Performance Measure #5
In 2004, the remaining form steps of the 10 criteria were accomplished.

a. Last Year's Accomplishments

All 10 of the indicators related to developing a Statewide Genetics Plan were achieved. The genetic planning team conducted numerous activities of the HRSA Genetic Planning Grant this past year leading to the development of the CT Genomics Action Plan. Various meetings were held of established GENE Team members and the Genetics Stakeholders Advisory Group. DPH provided workshops in Public Health Genetics. These workshops included topics in genetics relevant to public health, Medical Applications of Genetics, and Population Screening. These workshops, which were taped for future use by others within DPH who become interested in the topics, were offered by Drs. Sharon Krag and Neil Holtzman of Johns Hopkins School of Public Health.

A genetic needs assessment was developed through utilization of contracted services of NERGG, Inc. The survey was distributed to three key groups in state: consumers/families, genetics professionals, and general medical providers for completion. The information gathered from the surveys was considered in the development of the CT Genomics Action Plan.

An assessment of internal data management infrastructure needs was performed and a data infrastructure development plan was created. A series of genetics workshops and a genetics symposium toward the goal of a more informed public health workforce were held. Plenary sessions included a variety of genetic emerging issues as genetics is integrated into public health. Presentations were provided by nationally known experts in the field of genetics and addressed such topics as: Genetics 101 basic information, ethical, legal, social, consumer needs, and other emerging issues as genetics impacts public health.

The DRAFT CT Genomics Action Plan was developed, reviewed by the GAC, Stakeholders, and Gene Team members for edits, comments, and additional information. The revised plan was submitted to DPH Commissioner for review. The Commissioner has adopted the plan and a Virtual Office of Genomics was established in May 2005 that will assist in the implementation of the CT Genomics Action Plan.

Genetic resources in CT were assessed and a CT Genetic Resources Directory was developed through contracted genetic services of NERGG, Inc. The first print was generated and provided distribution to a broad variety service providers and consumer organizations in CT as well as to

other New England DPH and MCH programs and organizations and consumers.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Convene and maintain a stakeholders advisory group for genetics.				X
2. Conduct a statewide genetics needs assessments of families and primary care physicians.				X
3. Develop a data integration plan for DPH child health related data.			X	
4. Develop and conduct education programs in genetics and its role in public health.			X	
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Revisions to the CT Genomics Action Plan will be incorporated as appropriate to maintain a comprehensive State Genomics Plan.

The Genetics Stakeholders Advisory Group and Gene Team members will continue to meet and serve as resource to others in public health and the VOG. The VOG will assist with the activities of implementation of the plan. Meetings and timelines for activities of the plan were established and will be implemented through the VOG.

The Genetics Planning Team recently collaborated on a Regional Genetics Collaborative proposal, submitted to HRSA in January 2004 by NERGG, INC for Genetics NBS Education Project. This grant was awarded to NERGG, Inc.

c. Plan for the Coming Year

The internal core DPH "Gene Team" will continue to serve as an important genetics resource for the Department. Further educational strategies and programs on genetics and public health are needed, and will be developed and proposed, including distance-learning possibilities. These educational programs will continue to target public health professionals, genetics professionals and general medical providers workforce development in genetics.

The Genetics Planning Team will continue to partner and collaborate with NERGG New England NBS Coordinators and genetic health professionals on the HRSA funded New England collaborative Genetics NBS Education Project. CT will continue to implement the CT Genomics Action Plan as we strive for integration of genetics into public health. Other opportunities for collaborative grants will be sought to address the gaps and barriers to the integration of genetics into public health.

State Performance Measure 6: *The degree to which the Connecticut State Department of*

Public Health has the infrastructure in place to collect and report accurate information on pregnancy-related mortality.

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective		2	4	5	6
Annual Indicator	1	3	5	5	6
Numerator	1	3	5	5	6
Denominator	7	7	7	7	7
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	7	7	7	7	7

Notes - 2002

In 2002 DPH efforts realized the accomplishment of two more of the seven criteria that comprise this measure. These were:
1) A comprehensive maternal record abstraction form is developed in collaboration with an obstetrical/gynecologic consulting agency for review of hospital and other records in cases of suspected pregnancy-related mortality., and
2) All pregnancy-related deaths are reviewed at regular intervals in conjunction with the Connecticut State Medical Society's Perinatal Morbidity and Mortality(PMM) and Maternal Mortality (MM) subcommittees.

Notes - 2003

24. State Performance Measure #6
No additional steps were completed in 2003. 5 of 7 steps have been accomplished to date.

Notes - 2004

24. State Performance Measure #6
One additional step was completed in 2004, namely, criteria #1: The state death certificate includes a check-off box to indicate pregnancy within one year of death for women of childbearing age. 6 of 7 steps have been accomplished to date.

a. Last Year's Accomplishments

During FY2004 six of the seven objectives for this performance measure were achieved. Connecticut met its target of six objectives. The Pregnancy Mortality Surveillance Program (PRMS) traditionally consisting of a review of pregnancy-related deaths, in collaboration with the Connecticut State Medical Society's Maternal Mortality Subcommittee, had continued state funding. The PRMS consultant conducted 2 educational sessions on maternal mortality issues in Connecticut to providers in hospital grand rounds and at the statewide workshop.

The Federal State Mortality & Morbidity Review Support (SMMRSP) grant enabled the pregnancy-related mortality review process to increase its collaboration with other related fatality review processes in Connecticut. As part of the SMMRSP grant, a statewide workshop

was convened to provide state and local agencies that conduct mortality review, an opportunity to increase collaboration and communication between the review processes, and increase awareness of existing resources. Collaborative state and local agencies participants in the workshop included local community Fetal and Infant Mortality Review (FIMR) programs, PRMS program, Office of Child Advocate (OCA), Office of the Chief Medical Examiner (OCME), Department of Children and Families (DCF) and law enforcement.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Attend meetings with Connecticut State Medical Society Mortality Review Sub-committee to review cases of pregnancy-related mortality.				X
2. Identify additional data sources for enhancing case ascertainment				X
3. Implement recommendations from Perinatal State Health Plan that relates to maternal mortality.				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The vital records data matching program, which matches deaths of women ages 10-54 with infant birth and death certificates, has been useful in increasing the number of pregnancy-related deaths reported. This information is provided to the consultant on a quarterly basis. A major accomplishment was the addition of the check-off box on the death certificate, which identifies pregnancy within one year of death. Since this is relatively new, data from the check off box has not been fully collected and analyzed. Discussion is underway with vital records staff to identify and include more data from the death certificate on the monthly ?report of death certificates' provided to the consultant.

One of the findings of the Perinatal State Health Plan determined that the enhancement of data collection to increase case ascertainment renders annual comparisons of the data suspect. The number of maternal mortality cases was underrepresented due to challenges in case ascertainment. Rates are not representative of true increases/decreases due to the influence by differences in case ascertainment practices year to year. Continued progress in this area will be partially dependent upon sustaining the work of the Perinatal Health Advisory Committee.

To enhance the process of case ascertainment, the DPH sent a letter to the Office of the Chief Medical Examiner (OCME) requesting his office provide access to data on pregnancy related mortalities. Additionally, a letter was sent to the Connecticut Hospital Association requesting access to hospital discharge data. Availability of these data sources will enhance the activities provided by the PRMS consultant for case ascertainment.

c. Plan for the Coming Year

The consultant will finalize the 10-year Pregnancy Related Mortality surveillance report for

deaths that occurred from 1991-2000. The report will provide information for addressing maternal mortality and recommendation for future prevention activities.

Staff will work with agencies, including The CT Hospital Association to gain access to hospital discharge, OCME and other Health Department data sources that could possibly provide the consultant with additional information for enhanced case ascertainment.

In partnership with DPH, the PRMS consultant will identify preventable causes of pregnancy-related mortality and present 2-3 collaborative educational strategies to other professionals (i.e. grand rounds) to prevent such deaths.

State Performance Measure 7: *The degree to which the State of Connecticut Department of Public Health improves education, diagnosis, and case management for asthma.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective		1	8	11	12
Annual Indicator	0	1	8	10	14
Numerator	0	1	8	10	14
Denominator	14	14	14	14	14
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	14	14	14	14	14

Notes - 2002

In 2002, DPH accomplished 7 more of the 14 criteria that comprise this measure.
These included:
a) Assess asthma-related activities (including direct services, education, and data collection) within:
1) the School-Based Health Centers,
2) Community Health Centers and
3) the CSHCN program where a review was also conducted of how asthma care is managed including whether home evaluations are provided as part of case management and care coordination;
b) Implement data collection and evaluation methods to determine whether children with a diagnosis of asthma have an asthma management plan in Community Health Centers;
c)Participate in the newly-formed Coordinated School Health Program to enhance asthma activities within schools in Connecticut;
d)Develop and implement a training/resource manual with Infoline for daycare providers and schools on managing asthma.; and
e)Continue to enhance asthma surveillance activities incorporating Title V data as it becomes

available.

Notes - 2003

25. State Performance Measure #7
In 2003, DPH accomplished 2 more of the 14 criteria/steps that comprise this measure, totalling 10 of the 14 accomplished thus far.
The 2 new steps accomplished were:
1) Among children with special health care needs diagnosed with asthma, implement evaluation of asthma triggers in homes by the CSHCN case manager; and
2) Using information gathered from the asthma needs assessments, implement activities related to asthma education, diagnosis, or management that assist the Community Health Centers(CHCs) in providing services to children with asthma.

Notes - 2004

25. State Performance Measure #7
In 2004, DPH accomplished the remaining 4 of the 14 criteria/steps that comprise this measure.

a. Last Year's Accomplishments

Community Health Center, Inc. completed year 3 of the HRSA Health Disparities Collaborative for Asthma. Hill Health Center and Staywell Health Center completed the 3-year service research asthma grant with the Agency for Healthcare Research and Quality (AHRQ) in which all child/adolescent participants showed a level of improvement of managing their asthma. Charter Oak Health Center participated in the Easy Breathing program working in collaboration with Dr. Cloutier at CT Children's Medical Center.

The DPH Asthma Program produced an easy-to-read manual (Managing Asthma in Connecticut Child Care Facilities: A Resource Guide). This was disseminated to CHC Medical Directors, some preschool providers, and childcare providers across Connecticut so that they would have access to asthma related education materials.

The CYSHCN Program is progressing with its transition from two to five Regional Medical Home Support Centers (RMHSC) for CYSHCN and their families/caregivers. These Centers are strengthening the family-centered approach to providing coordinated ongoing comprehensive care for CYSHCN within their medical homes. This ensures that all children will be screened early and continuously for special health care needs such as asthma.

The Asthma Program was involved in the Asthma Action Plan Revision Project, the development of the "Teen Toolbox" (delivers health education through engaging media such as CDs and videos to appeal to the preferred learning styles of adolescents), and the participation on the "Tools for Schools Resource Team". The program supported regional implementation of the statewide asthma plan recommendations. Informational meetings were conducted to assist regions in the implementation of the Asthma State Plan. CHC's and SBHC's were involved in the regional meetings.

Public Awareness activities were conducted and included website health promotion and education, and PSAs in both English and Spanish. PSA listeners were encouraged to call 2-1-1 Infoline to get more information about asthma. Demographic information on the callers was collected to determine the effectiveness of the campaign in reaching the target population

SBHCs provided services to enrolled students that encompassed asthma screening as well as acute and chronic care.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

	Pyramid Level of

Activities	Service			
	DHC	ES	PBS	IB
1. Maintain asthma workgroup to build capacity within TV programs to enhance asthma awareness.				X
2. Assess asthma related activities within the SBHCs, CHCs and the CSHCN Program.				X
3. Participate in the CSHP to enhance asthma activities within schools in CT.				X
4. Continue and enhance asthma surveillance activities incorporating Title V data.				X
5. Implement data collection methods to determine whether children have an asthma management plan.				X
6. Implement activities related to asthma education, diagnosis, or management.				X
7.				
8.				
9.				
10.				

b. Current Activities

The Asthma Program continues to support SBHC and CHCs by collaborating with DPH staff and sharing asthma--related data, such as the implementation of the statewide asthma plan recommendations on a regional basis. The CHCs participate in the community informational meetings convened by the DPH Asthma Program across CT.

Over half of the 11 CHCs corporations and their sites are involved with a national best practice Asthma Management collaborative with one of the following federal agencies: HRSA; AHRQ; and NIH. Also, the majority of the CHCs are involved with the Easy Breathing (funded by DPH) components. Three CHCs and their sites are participating in regional community meetings in three distinct geographical area of CT.

SBHCs continue to focus on asthma-related issues such as education and preventive care. SBHCs identified gaps and barriers to adequate asthma management in their midyear reports. Some of these issues were related to lack of adequate supplies and lack of asthma management awareness. SBHCs identified the need to improve collaboration and communication with community health providers in the use of the Asthma management plan.

The CYSHCN Program will continue to expand care coordination activities through implementation of the statewide RMHSC system of care to improve the triaging of CYSHCN based on severity/complexity level and coordinate referral to the appropriate specialists.

All children with asthma receive environmental assessment and family education upon intake, at routine care coordination meetings with the PCP and upon referral to a Pulmonologist as needed. Families are encouraged to work with their PCP and/or specialist when issues arise relating to care coordination. Basic family education is provided as needed by CYSHCN care coordinators.

The Breath Express Asthma education van continues to provide outreach education in schools around the state and is available for Community Health Center venues during school vacations and the summer.

The Asthma Action Plan form (incorporating a Spanish patient copy) has been modified to include the names of asthma triggers, severity level and a provider instruction sheet. This information will be shared with the Commissioners of DPH and Education, as they are members of the workgroup. There will be a wide distribution to SBHCs, CHCs, Family Health Practitioners, Pediatricians, Pulmonologists and Allergists.

The Asthma Program evaluated the "Teen Toolbox" and plans to make revision to enhance the use of the Tool Box".

DPH nurse consultants participated in the Asthma Partner's Meeting on May 19, 2005 convened by DPH and supported by the CDC. Some CHCs and SBHCs have already been involved with regional meeting toward the goal of developing an infrastructure within which asthma can be addressed. One of the priorities is to train physicians/providers in Easy Breathing curriculum, which is funded by DPH.

c. Plan for the Coming Year

SBHC will continue to provide asthma-related health services in all 63 sites. To address one of the barriers identified in the SBHC Midyear reports (lack of supplies by students) two more SBHCs will be joining the asthma urban school pilot project. As part of that project, they will be provided with free durable medical equipment such as tubing and nebulizers.

The remaining CHCs and their sites will participate in regional community meetings. In addition, they will continue to provided preventive, primary care, and chronic disease management to asthmatic children and adults.

The Asthma Action Plan Workgroup will evaluate and implement strategies for increasing utilization of the revised Asthma Action Plan.

Putting on Airs, a CDC funded asthma home environmental assessment initiative being implemented in 5 areas of the state, will include CHCs and SBHCs as critical referral sources.

The DPH program nurse consultants for both the statewide CHCs and SBHC will disseminate the Asthma newsletter to their contractors.

The CYSHCN Program will be progressing with and evaluating its transition to a statewide comprehensive system of care for CYSHCN and their families/caregivers. The family-centered approach to coordinated ongoing comprehensive care for CYSHCN within a medical home will continue to be promoted and supported by The Regional Medical Home Support Centers. This system will ensure early and continuous screening for special health care needs such as asthma. The program will work to promote community-based service systems which are organized so the CYSHCN and their families/caregivers can access and use them easily. Families/caregivers will partner is decisions making at all levels and will be satisfied with the services they receive.

State Performance Measure 8: *Percent of community-based public health care facilities that provide comprehensive dental services for needy or vulnerable children and their families.*

Tracking Performance Measures *[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]*					
Annual Objective and					

Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	35%	37%	38.5%	36	42
Annual Indicator	33.3	36.3	42.5	41.2	41.2
Numerator	29	37	48	49	49
Denominator	87	102	113	119	119
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	42	43	44	45	45

Notes - 2002

CT reported CY 2002 data last year. The form will not allow for reporting of CY2003 data which we now know to be 38/106 or 35.8%. Oral Health services have been reduced due to budget difficulties across the state.

Notes - 2003

26. State Performance Measire #8
CY2003 survey of safety net providers. Oral Health Services have been reduced in scope in many places due to budget difficulties across the state.

Notes - 2004

26. State Performance Measure #8
No new cy2004 survey was conducted. Data is from CY2003 survey of safety net providers. Oral Health Services have been reduced in scope in many places due to budget difficulties across the state.

a. Last Year's Accomplishments

DPH continues to receive multiple requests to present OPENWIDE to various non-dental health and human service workers across the state. Priority is still being given to training non-dental providers who work with children age 0-5 years. Several communities are now using the program as a means to raise awareness and educate the public about the importance of oral health to general health and well-being.

DPH was represented at a Community Meeting hosted by the Yale Prevention Research Center to launch a community-based participation model and discuss how Yale can support community members and organizations.

An adaptation of the OPENWIDE program was developed specifically for early childcare providers in collaboration with UCONN, CT Charts a Course and the CT Resource Academy.

A Dental Summit was held in June 2004 to bring together a constituency concerned with the status and future of oral health and oral health care access in CT. DPH collaborated with partners including Southwest Area Health Education Center, Connecticut Health Foundation, Connecticut State Dental Association, Connecticut Oral Health Initiative and the Connecticut Department of Social Services. The priority/strategy of the conference was to build a common oral health vision for Connecticut by developing an outline for a proposed state oral health plan during the upcoming year.

An RFP for an independent evaluation of the OPENWIDE training program was issued but implementation has been postponed.

Several meetings with the state's Managed Care Organizations were held to discuss enhanced billing and data collection but follow-up was postponed until a decision is made about the Medicaid dental plan.

DPH dental contract spending plan for dental services in FY 2004 included 4 School Based Health Centers (SBHCs) and 4 Community Health Centers (CHCs). However, it is up to the discretion of each site on how this money is used. Limited data is received from these SBHCs, CHCs and other dental safety net facilities and the dental data reporting is often incomplete, inconsistent, and not comparable.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Create, support & provide technical assistance to statewide public-private oral health collaboration				X
2. Provide technical assistance and state funding to CHC and SBHC dental programs.				X
3. Expand & implement OPENWIDE, an oral health integration & training program for non-dental health professionals				X
4. Explore means to expand programs that increase number of dental students/residents working in public.				X
5. Enhance data/data systems to improve oral health assessment, surveillance and evaluation.			X	
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Over $2 million in funding to expand community access to dental care has been approved by the state Bond Commission. This funding is planned for projects in 11 cities and towns, ranging from school-based dental clinics to mobile dental care centers. Much of the money is targeted to urban areas, where the majority of the state's Medicaid-enrolled children live but only about 20% of the state's dentists practice.

Bridgeport Health Department is working on an agreement with the local community health center to have one of their dentists work in one of their clinics at least one day a week. Staff continues to coordinate referral services with agencies in the area for follow-up treatment when possible.

Hartford Public School Systems Dental Program continues to grow with a mobile van now providing services 4 days a week (up from 3 days last year, and is now also serving an additional school).

Stamford School Based Health Centers have been successful in seeking and obtaining

additional revenues that allowed them to add 3 additional operatories in three school buildings. Dental hygienists are now able to clean the students' teeth as well as provide screening exams.

CT is represented on the American Association of State and Territorial Dental Directors School and Adolescent Oral Health Committee. The purpose of this committee is to serve as a resource and offer technical assistance to state oral health directors to promote awareness and improve oral health of children and adolescents in schools through collaborative partnerships and education.

OPENWIDE was used by the American Academy of Pediatrics in their development of an oral health risk assessment for pediatricians.

A survey of all CT OB/GYNs to assess interest in implementing oral health risk assessment protocol in offices if they were provided the tools and training was completed.

A second training session was scheduled and held for Head Start Health Managers who missed getting training on OPENWIDE the first time so that all of the Head Start Health managers had the opportunity for the training if they desired. Approximately 30 Head Start Health Managers participated in training.

A PowerPoint presentation was made to school superintendents in northeast CT as part of their regional meeting that effectively convinced 6 school districts that allocation of funds for dental screening is important to school health and economically feasible. Further work is also being done to investigate the possibilities of developing "health academies".

Staff submitted a successful application for HRSA'S State Oral Health Collaborative Systems grant. The proposed activities for this 3-year project will culminate in the development of a dental sealant program.

c. Plan for the Coming Year

The data and information systems for oral health will be enhanced, enabling improved monitoring and reporting of the prevalence of dental sealants. Focus groups are planned with key stakeholders to try and resolve billing and data issues, which will ultimately enhance our ability to monitor and report the prevalence of dental sealants. Lessons learned from the IDEAS project will be used in developing the oral health and information monitoring systems.

OPENWIDE training of non-dental professionals during the coming year will include more obstetricians, gynecologists, pediatricians, family practice physicians and nurses who also treat school age children. Preventive measures promoted for this group of children includes dental sealants. Therefore, we hope to see an increase is the number of sealants placed as a result of pediatricians, nurses and family practice physicians making appropriate referrals for dental care.

DPH is partnering with the American College of Obstetricians and Gynecologists, and the CT Chapter of The March of Dimes to add a module to the existing OPENWIDE curriculum for Obstetricians. The additional module would promote oral health screenings during the prenatal visits and the long-term goal is that the curriculum is integrated as a standard part of prenatal care.

The first step of the project was to conduct a survey of all licensed OB/GYNs in CT to determine current practice with regards to oral health and level of interest in this project. An Advisory Committee will be convened consisting of key stakeholders such as the CT State Dental Association, ACOG, March of Dimes, University of Connecticut Dental School, Healthy Start representation and others to review the analysis and provide direction for adapting the

OPENWIDE curriculum for OB/GYNs.

State Performance Measure 9: *The degree to which the Connecticut State Department of Public Health has the infrastructure in place to collect and report information on all children with special health care needs in the State.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	4	10	16	17	15
Annual Indicator	4	7	9	13	13
Numerator	4	7	9	13	13
Denominator	18	18	18	18	18
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	15	15	16	17	18

Notes - 2002

In 2002 DPH accomplished two more of the eighteen criteria that comprise this measure, namely,
1) Added a module to the electronic Newborn Screening System for reporting cases to the CSHCN Registry from birthing units and NICU's(front end).; and
2)Created a single point of referral to CSHCN Ctrs for all CSHCN.

Notes - 2003

27. State Performance Measure #9
In 2003, DPH accomplished 4 more of the 18 criteria that comprise this measure resulting in 13 of the 18 steps accomplished to date.
The 4 newly accomplished steps include:
1) Initiate a CSHCN Registry Advisory Committee with representation from the disciplines of epidemiology, hospital administration, maternal & child health, genetics, early intervention, the March of Dimes, family advocacy, & public health; and
2) Begin receiving reports of cases from the module added to the electronic Newborn Screening System;
3) Begin tracking referrals of newborns to CSHCN Centers and the Birth-to-Three program using the module added to the electronic Newborn Screening System; and
4) Begin using the CSHCN Registry's data management system by the end of 2002.

Notes - 2004

27. State Performance Measure #9
In 2004, no new steps were accomplished. To date, 13 of the 18 criteria have been met.

a. Last Year's Accomplishments

Last year, the CSHCN Registry achieved 13 of the 18 indicators for this performance measure, however the objective of meeting 15 was not met. In October 2003, an epidemiologist was hired to oversee the CSHCN Registry. Due to prior staff turn over, the compliance of reporting from birth facilities had been poor. The new staff made contacts with nurse managers in birth facilities and visited the birth facilities to provide information and education. To improve reporting compliance, presentations were made in grand rounds and meetings. Reports for monitoring the compliance were generated and forwarded to nurse managers routinely for comparisons with other hospitals to reinforce the reporting requirements.

Infoline has become the single point of referral for all children with special health care needs. Children who are reported to the CSHCN Registry from birthing and neonatal intensive care units are referred to the CSHCN Centers and Birth to Three System by the service provided by Infoline. A data collection tool for Infoline was developed and these data are to be submitted to the DPH to be analyzed and monitored for the referral services provided to CSHCN.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue to enhance data system for CSHCN.			X	
2. Plan and implement a web-based reporting system for medical homes (PCPs) to record and report information on CSHCN population				X
3. Utilize InfoLine as the single source for CSHCN referrals		X		
4. Conduct regular Medical Home Learning Collaborative (MHLC) meetings				X
5. Continue to conduct information/education sessions on the Birth Defects Registry and CSHCN program f to increase public/professional awareness of the importance of reporting information.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Since May of 2004, 29 of 31 birth hospitals have been reporting CSHCN cases to the DPH with good compliance; however, both the University of Connecticut Health Center (UCHC) and Yale New Haven Hospital are not reporting cases to the Registry through the Newborn Screening System (NBS). UCHC has been sending electronic data to DPH on a monthly basis and these data are incorporated into the Registry through a module that is linked to the NBS data. Yale New Haven Hospital has been sending hard copy of reports to the DPH and data are entered into the Registry manually at the DPH. The compliance of CSHCN reporting from hospitals to the Registry has been estimated as 82%, a significant improvement from the past years.

It is planned to have a web-based reporting system for primary care providers (PCPs) to collect and report CSHCN information to the DPH for surveillance and planning purposes. As the implementation of medical home system in CT, DocSite is identified as the vender for this system. DocSite has partnered with NICHQ for the Medical Home Learning Collaborative (MHLC) at the national level and has been used by 2 pilot groups in the state, including Stamford Pediatrics and St. Mary's Hospital. The Patient Planner and Population Planner in the

DocSite system integrate the chronic disease model and the registry concept, which fits this purpose well.

Discussions have been ongoing between DPH and DocSite to further modify the system to include a CSHCN module to meet the needs of DPH. As there are five regions across the state under the medical home system, each of the regional centers will have access to CSHCN records entered by medical homes in the respective regions. DPH will have access to all the CSHCN records in the system from five regions that provide the full coverage statewide. DocSite is expected to go live in April 2005.

Several presentations relating to CSHCN Registry were made at national conferences. A project entitled "Referral pattern of children with special health care needs in Connecticut" was selected and presented in the MCH EPI conference during December 2004 in Atlanta. Another project entitled " Completeness of case reporting in the Connecticut Birth Defects Registry" was selected and presented at the National Birth Defects Prevention Network meeting during January 2005 in Scottsdale, Arizona.

c. Plan for the Coming Year

Regional medical home support centers (RMHSC) will be responsible for recruiting additional medical homes within its region to participate in the system as the contracts for the RMHSC are implemented. It is expected that using DocSite for data collection, will maximize information management efficiently and effectively and enable more CSHCN to be served. RMHSC will be able to use the customized queries in the DocSite system to generate information to be included in reports, both quarterly and annually, and submit them to the DPH. RMHSC will also be able to use the data collected in the DocSite system to identify the improvements needed to provide better services to CSHCN in the respective regions. DPH will be able to use the data collected in the DocSite system for enhanced planning and resources allocation statewide, which will ultimately better serve the CSHCN in the state.

E. OTHER PROGRAM ACTIVITIES

Many other programs within DPH affect the MCH population but are not funded through MCHBG. Some of these are listed below:

The Abstinence-Only Education Initiative supports community-based abstinence-only education programs, to promote abstinence from sexual activity among racially and ethnically diverse, nine- to 14-year-old males and females.

Asthma program's mission is to reduce asthma-associated morbidity and mortality and improve the quality of life for people with asthma. The asthma program and FHS staff have collaborated to assess Title V program data and activities to develop interventions for children diagnosed with asthma.

Breast and Cervical Cancer Early Detection Program provides screening and diagnostic services through 18 primary health care facilities and over 100 subcontractors throughout the state. The program provides case management and community-based education and outreach targeting medically underserved women.

Childhood Lead Poisoning Prevention Program operates a comprehensive lead surveillance system, provides professional and community education services and operates 2 regional lead treatment centers. The DPH laboratory provides blood lead testing.

Chlamydia Infertility Prevention provide free chlamydia screening and treatment services to females and their partners who attend targeted Planned Parenthood clinics.

Comprehensive STD Prevention Systems Projects provides services to reduce the transmission and incidence of STDs including surveillance to monitor the trends facilitating individual case intervention.

Enhanced Perinatal HIV Surveillance receives CDC funding to conduct surveillance. All perinatal HIV exposures (appx 75 infants per year) are followed-up with medical record reviews to collect information about maternal HIV testing, prenatal care, risk factors, treatment compliance, etc.

"Five-a-Day" Head Start Project focuses on providing direct nutrition education to Food Stamp eligible families in CT with the "Captain 5-A-Day" program for children and the "Supermarket Smarts" program for parents and families. These programs are delivered through workshops by state nutrition staff and provide education on food budgeting and developmentally appropriate feeding practices, and encourage dietary behavior modification including the purchase and consumption of fruits, vegetables and other low-fat foods.

Healthy Child Care CT more than 50 organizations that play a key role in the planning and delivery of child care and health care for children and families. Leadership is provided by a collaborative effort of DPH, DSS, and the Children's Health Council through the CT Head Start State Collaboration Office.

Immunization Program activities are designed to prevent disease, disability and death from vaccine-preventable diseases in infants, children and adults. The Immunization Action Program funds 11 full time health departments, 2 health districts, and 4 additional community providers to conduct activities to raise immunization rates and the Vaccines for Children provides free vaccines to over 500 health care providers to eliminate cost as a barrier to receiving immunizations. Also, The CT Immunization Registry and Tracking System permanently records and tracks all CT children's immunizations given in childhood.

Intimate Partner Violence prevention is addressed at hospitals statewide by providing training to health, mental health and public health professionals, paraprofessionals and students statewide regarding intimate partner violence issues, screening and appropriate referral.

Perinatal Hepatitis B Prevention: All hepatitis B positive pregnant women and their providers are contacted to provide education about the implications of hepatitis B infection in pregnancy, offer testing and vaccination to family members and ensure that the infant receives appropriate immunization and testing.

Ryan White Care Act provides federal support for comprehensive health and social services for people living with AIDS and HIV disease, including women, infants and children. There are many AIDS activities aimed to serve women, infants, and adolescents.

Sexual Assault Prevention and Intervention Services ensures the provision of direct services for victims of rape and other sexual assaults throughout the state. DPH contracts with the CT Sexual Assault Crisis Services, Inc., an umbrella agency, to coordinate these efforts.

WIC serves approximately 55,000 participants in CT. They include low income pregnant, breastfeeding and postpartum, non-breastfeeding women, as well as infants and children up to five (5) years.

WISEWOMAN (The Well-Integrated Screening and Evaluation for Women Across the Nation Program) incorporates cardiovascular disease screening and intervention services into the healthcare delivery system at nine contracted health care provider sites.

F. TECHNICAL ASSISTANCE

The Connecticut DPH has been an active participant in the Technical Assistance Program, most often receiving aid but has provided reverse technical assistance to other areas as well. As seen on Form

15, Technical Assistance Request, this year's requests fall into the General Systems Capacity and National or State Performance Measure categories.

The first issue identified as a General Systems Capacity issue, DPH requests assistance in the form of a physician speaker, on Cost and Outcomes of need for care coordination as part of Medical Home improvement for CYSHCN at 10 pediatric hospital based grand rounds.

DPH identified another General Systems Capacity issue related to adolescent health. CT needs assistance to collaborate with other state and territorial adolescent health coordinators in order to improve access to national resources and experts on adolescent health.

In relation to NPM 2, DPH would like assistance in facilitating members of the Family Support Network to organize a plan for enhancing parent partnerships with the medical homes in CT that serve CYSHCN.

In relation to NPM 8, DPH would like assistance in providing training to stakeholder agencies on evidenced-based, culturally appropriate approaches to sexuality education, as identified in the State Adolescent Health Plan.

In relation to the newly developed SPM 4, DPH would like assistance through a consultant to conduct a comprehensive assessment of the statewide SBHC database to ensure appropriate system is being utilize to promote compliance and consistency in reporting, as well as SBHCs ability to obtain reimbursement for services.

Lastly, DPH identified a need for assistance related to the newly developed SPM 6 to present to community-based MCH contractors, best-practice models that are culturally appropriate for engaging pregnant teens in early prenatal care.

V. BUDGET NARRATIVE

A. EXPENDITURES

There were many overall factors that impacted the actual expenditures in comparison to the FFY2004 budget. More details specific to each of the Budget Forms are described below.

Form 3

For FFY2004, not all of the Federal Allocation was spent for several reasons. Several professional staff moved to other positions, and in combination with a delay in filling other Title V funded vacancies. Payment for services for the Health Start Program was put on hold due to a contractual dispute (for a different contract) with the Department of Social Services (DSS). The money will be paid out in the near future.

State funds expended differs from budgeted due to an increase in certain program activities, and payments from the previous fiscal year. Specific programs contributing to the difference in amount expended than budgeted were the Genetic Sickle Cell programs, CSHCN Clinics, Family Planning, and School Based Health Centers.

Form 4

A review of program activities resulted in a shift of the apportionment of funding among the population groups served with the MCHBG funding and the Maintenance of Effort/State Match funding. Similarly, the reapportionment of staff time to different population groups as well as a shift in the selection of State programs used to comprise the State Match account for differences in amount expended on CSHCN contributed to the difference in expended versus budgeted. Extended vacancies for administrative support accounted for the difference in administrative expenditures, and an extended vacancy for key positions, staff phycisian and oral health director, account for the part of the difference in amount expended for Children age 1-22 and CSHCN.

Form 5

Among the contracts and programs supported through the MOE and the MCHBG there was a shift in the way there was accounting for these services among the levels of the service pyramid. The addition of several new staff in FHS accounts for the difference in amount expended in population--based services and enabling services.

B. BUDGET

State matching funds are met through funding of School-Based Health Centers, The Genetics Diseases Program, and the CSHCN/RMHSC Clinics. These matching funds will total $3,968,000 for FFY 2006. For FFY 2006, the maintenance of effort requirement is met from several sources: Community Health Centers, Family Planning Programs, and the School-Based Health Centers located throughout the state. The State of Connecticut dollars for these programs total $7,093,000 for FFY 2006 (maintenance of effort total includes the matching).

Other state-funded programs that serve the maternal and child health population include: Community Health Centers, Lead Poisoning Prevention, Asthma, Genetic Sickle Cell Program, Healthy Choices for Women and Children, Expanded School Health Services, Rape Crisis and Prevention Services, Oral Health, Pregnancy Related Mortality Surveillance, Fetal and Infant Mortality Review, and Family Planning. In addition to these programs, there are several state-funded DPH personnel who provide support to the maternal and child health programs.

The requirement that there be three dollars of State matching funds for each four dollars in federal funding is met for FFY 2006. The federal allocation for FFY 2006 is $ 4,974,598 which means that the State of Connecticut must match with at least $3,730,948. Three dollars and nineteen ($3,968,000) is

funded for each four dollars in federal funds awarded. Maintenance of Effort for FFY 2006 is in the amount of $7,093,000, which is $315,809 more than the required FFY 89 base of $6,777,191.

Other federal grants received by DPH that serve the maternal and child population include: Abstinence Education, Youth Violence and Suicide Prevention, Rape Crisis and Prevention, Genetics Planning, Universal Newborn Screening, State Systems Development Initiative (SSDI), and the Health Care Provider Loan Repayment program.

The allocation plan requires that 30% of the FFY allocation be budgeted for Prevention and Primary Care services, as well as 30% for Children with Special Health Care Needs. For the FFY2006 award amount, $1,548,761 (31.13%) is allocated for Preventive and Primary Care for Children; and $1,599,622 (32.16%) for the CSHCN program. There is an allocation of administrative costs of $185,175 (3.72%) of the projected federal allocation to all programs.

In FFY 2006, the federal allocation is $4,974,598 plus using $345,563 of the carry forward from FFY 2004 for a total of $5,320,161 of federal funding. When combined with the state funds of $7,093,000 there is a federal-state block grant partnership total of $12,413,161.

VI. REPORTING FORMS-GENERAL INFORMATION

Please refer to Forms 2-21, completed by the state as part of its online application.

VII. PERFORMANCE AND OUTCOME MEASURE DETAIL SHEETS

For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

VIII. GLOSSARY

A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

IX. TECHNICAL NOTE

Please refer to Section IX of the Guidance.

X. APPENDICES AND STATE SUPPORTING DOCUMENTS

A. NEEDS ASSESSMENT

Please refer to Section II attachments, if provided.

B. ALL REPORTING FORMS

Please refer to Forms 2-21 completed as part of the online application.

C. ORGANIZATIONAL CHARTS AND ALL OTHER STATE SUPPORTING DOCUMENTS

Please refer to Section III, C "Organizational Structure".

D. ANNUAL REPORT DATA

This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.